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Issue date: 09Jul2002

***In the Matter of*:**

CASE NO. 2001-LHC-2013
OWCP NO. 18-69222

TERESA FAYE CLAYTON,
Claimant,

vs.

NAVY PERSONNEL COMMAND/MWR
Respondent,
and

CONTRACT CLAIMS SERVICES, INC.,
Carrier.

Appearances:

Richard Mark Baker
115 Pine Avenue, 5th Floor
Long Beach, California 90802
For Claimant Teresa Faye Clayton

William N. Brooks
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For Employer/Carrier Navy Personnel Command/MWR
and Contract Claims Services, Inc.

Before: Anne Beytin Torkington
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This case involves a claim arising under the Longshore and Harbor Workers' Compensation Act, as amended (hereinafter "the Act" or "the Longshore Act"), 33 U.S.C. § 901 *et seq.* A formal hearing was held in Long Beach, California on January 16, 2002, in which all parties were represented by counsel and the following exhibits were admitted into evidence: Administrative Law Judge's Exhibits 1, 2, and 3 ("ALJX-1", "ALJX-2", and "ALJX-3")[1], Claimant's Exhibits ("CX") 1 through 11;[2] and Employer/Carrier's Exhibits ("RX") 1 through 21. Tr.14-15.[3]

The parties agreed to submit Post-Trial depositions of their expert witnesses. This Court received the Post-Trial deposition of Dr. Daniel A. Capen on February 27, 2002, ("CX-12"). On March 15, 2002, this Court received the Post-Trial deposition of Dr. James T. London ("RX-22"). On March 29, 2002, this Court received the Post-Trial deposition of Dr. Jens W. Dimmick ("CX-13"). On April 10, 2002, this Court received the Post-Trial deposition of Dr. Paul J. Grodan ("RX-23"). These exhibits are hereby admitted into evidence.

On April 16, 2002, Employer submitted its Proposed Decision and Order. On April 22, 2002, Claimant submitted, by fax, her Proposed Decision and Order. These are hereby admitted as Administrative Law Judge's Exhibits 4 and 5.[4] On May 8, 2002, this Court's law clerk spoke with counsel for Claimant who advised her that Claimant has withdrawn her claim for injury to her cervical spine, as originally alleged. Counsel for Claimant faxed a letter to the Court stating as much. This letter shall be admitted as Administrative Law Judge's Exhibit 6.

Stipulations: The parties agreed to the following stipulations:

1. The parties are subject to the Act;

2. Claimant and Employer were in an employer-employee relationship at the time the injury occurred;

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[1] Administrative Law Judge's Exhibits were Claimant's Pre-Trial Statement ("ALJX-1"), Employer/Carrier's Pre-Trial Statement ("ALJX-2") and the Director, Office of Workers' Compensation's ("OWCP") Pre-Trial Statement ("ALJX-3"). See Transcript, ("Tr.") at 132.

[2] Claimant's Exhibits were admitted provisionally, subject to further objection, post-hearing, on Exhibits 3 and 10. No further objection was made post-hearing. Thus, Claimant's Exhibits 1 through 11 are hereby admitted in their entirety.

[3] Hereinafter Employer/Carrier will be referred to simply as Employer.

[4] ALJX-4 is Claimant's Proposed Decision and Order, ALJX-5 is Employer's Proposed Decision and Order.

3. The injury to Claimant's lower back, sustained on October 5, 1998, arose out of and in the course of employment, but the parties are in dispute as to whether Claimant's gastrointestinal condition arose out of and in the course of employment;[5]

4. Claimant filed a timely claim for compensation;

5. Employer had timely notice of the injury;

6. Claimant's average weekly wage at the time of injury was $143.26;

7. Claimant returned to her former job, with no loss of earnings, on October 13, 1998;

8. Employer voluntarily paid compensation for temporary total disability from October 7, 1998 through October 12, 1998; from April 19, 1999 through April 20, 1999; from July 26, 1999 through July 28, 1999, and from August 26, 1999 through November 9, 1999;

9. Claimant is not now working, and has not returned to work since August 26, 1999;

10. Claimant is able to perform suitable alternative employment at or above her pre-injury average weekly wage.

The Court accepts all of the foregoing stipulations as they are supported by substantial evidence of record. See *Phelps v. Newport News Shipbuilding & Dry Dock Co.*, 16 BRBS 325, 327 (1984); *Huneycutt v. Newport News Shipbuilding & Dry Dock Co.*, 17 BRBS 142, 144 fn. 2 (1985).

Issues in Dispute:

1. Did Claimant's gastrointestinal condition arise out of or in the course of employment?

2. What is the nature and extent of Claimant's disability?

3. What is the date of maximum medical improvement, January 18, 2000, or October 13, 1999?

4. Is Claimant entitled to ongoing medical care after January 18, 2000?

5. Is Claimant entitled to Section 7 benefits for medical treatment by Dr. Daniel Capen?

6. Is Claimant entitled to a *de minimis* award after the date of maximum medical

[5]At trial, Claimant was also pursuing a claim for cardiovascular injuries and injuries to her cervical spine. Both of these allegations have since been withdrawn. See CX-13, p.18, ALJX-6.

improvement as it will be determined by the Administrative Law Judge?

7. Is Employer entitled to Section 8(f) relief?

8. Is Claimant entitled to attorney's fees and costs?

SUMMARY OF DECISION

Claimant's gastrointestinal condition did not arise out of or in the course of employment. Claimant's gastrointestinal condition was a pre-existing condition that was not aggravated by medication prescribed for her low back injury of October 5, 1998. Claimant is no longer disabled on an industrial basis. Claimant's low back injury reached maximum medical improvement on October 13, 1999. Claimant is not entitled to ongoing medical care after January 18, 2000, as her present condition is non-industrial in nature, and her low back injury, sustained on October 5, 1998, has fully healed. Claimant is not entitled to Section 7 benefits for medical treatment by Dr. Daniel Capen, as Claimant's industrial injury was fully resolved by October 13, 1999, and Claimant did not begin treatment with Dr. Capen until September 20, 2001.

Furthermore, Claimant is not entitled to a *de minimis* award for benefits after October 13, 1999, as there is not a significant potential that Claimant's low back injury of October 5, 1998 will cause diminished capacity under future conditions. Any low back pain Claimant continues to suffer from is degenerative in nature, and is not the result of an aggravation of her pre-existing condition by her industrial accident. The Court need not reach the issue of Section 8(f) relief, as Employer is not liable for any permanent disability payments. Claimant is not entitled to attorney's fees or costs, as Claimant has failed to prevail on any issue before this Court.

SUMMARY OF EVIDENCE

Claimant's Testimony:

Claimant, Teresa Faye Clayton, testified on her own behalf. Claimant testified that she was injured while working at the China Lake Golf Course on October 5, 1998. Claimant was stocking golf tees. Claimant then lifted a full box of tees which was sitting on top of the open box she intended to unpack. Claimant picked up the full box, and turned to put it down. She felt something pull in her back. She dropped the box of tees. Claimant continued to work, until her supervisor, Renee Swanson arrived, at which time Claimant reported the injury, and was told to report to the dispensary. Tr.37-38.

Claimant was examined by Dr. Hammond at the dispensary. Dr. Hammond took x-rays, gave Claimant some muscle relaxers, and told her to go home and rest. Claimant returned to the pro shop

instead. Claimant testified that Ms. Swanson did not allow her to leave. Claimant finished her shift. The next day, Claimant returned to the dispensary before her shift started, as instructed by Dr. Hammond. At this point, Dr. Hammond told Claimant to take the rest of the week off. Tr.38-40.

Claimant went to see Dr. Hammond again when she returned to work a week later. Dr. Hammond told her to stay home, but Claimant stated that she was not going to get paid, and she needed to go back to work. Dr. Hammond then released Claimant to work on light duty. Claimant was instructed to sit often, not to lift five or ten pounds, and no stooping. Claimant returned to work, but testified that she did not work within her restrictions. Tr.40-41. Claimant was forced to continue stocking merchandise, and moving it out of the way as it was delivered. Tr.42. Claimant stated that her supervisor would let her lie down in the locker room if she needed to, and told her to keep a chair behind the counter so she could sit when necessary. Tr.42.

At some point during the month following the injury, Dr. Hammond told Claimant she needed to see an orthopedic surgeon. She gave Claimant some names, and Claimant chose to see Dr. Smith. Tr.42. Claimant was first examined by Dr. Smith on December 2, 1998. CX-1, p.1. Dr. Smith sent Claimant for an MRI. He told Claimant that she had "a bulge, and that he thought that maybe the nerve was pinching," causing her pain. Dr. Smith sent her to physical therapy, and prescribed medication. Claimant remained in Dr. Smith's care for "seven months to a year." Tr.43.

Dr. Smith then recommended Claimant see Dr. Don DeFeo to corroborate his opinion that Claimant needed surgery. Tr.44, CX-1, p.4. Claimant was examined by Dr. DeFeo on March 4, 1999. CX-2, p.1. Dr. DeFeo recommended spine stabilization surgery, which Claimant declined because she "didn't want to have surgery." It scared her. Tr.46-47. Dr. DeFeo then recommended epidural injections and medication. Claimant was going to have the epidural injections but her insurance would not cover the procedure, and Claimant could not afford it on her own. Tr.47. Dr. DeFeo put Claimant on medication, and told her to keep taking it. Claimant testified that Dr. DeFeo never released her to go back to work. She stated that Dr. DeFeo actually recommended that she not return to work. Tr.48.

Claimant's Gastrointestinal Condition:

Claimant testified that she had first experienced stomach problems 22-23 years ago. She stated that she was taking medication for her back at that time. She testified that "they had did [sic] the tube down my throat, and they said that I had like acid reflux they thought." She was given a prescription for Prevacid,[6] and given over-the-counter medication, which cleared her problem. Claimant recalled that she was seen at Antelope Valley Hospital in February, 1990 and was diagnosed with possible reflux esophagitis. Claimant had reported at that time that she had experienced discomfort off an on for four years. See CX-8, p.11. On cross-examination, Claimant stated that she had not experienced any gastrointestinal problems between her first flare-up, and 1990. Claimant denied experiencing any stomach problems in 1990 as well. She denied having any symptoms

[6]A stomach-acid inhibitor and antiulcer prescribed for duodenal ulcers, esophagitis and Zollinger-Ellison syndrome. *The Pill Book*, 7th ed., 1996, p.584.

between 1990 and 1995. Tr.74-75. Claimant remembered going to the hospital in 1995, but stated that it was not for her gastrointestinal problem. See RX-8, p.44. Claimant recalled that she was put in the hospital for chest pain and a viral infection. Tr.75-76.

Claimant later testified further on cross-examination that in 1990, she was not hospitalized for her stomach. She did not recall having any testing done for that complaint. She did not recall reporting that she had been experiencing gastrointestinal problems for years prior to 1990. Tr.78. On re-direct, Claimant stated that she was admitted to Antelope Valley Hospital in February 1990 for her heart. They put her in cardiac care for quite a while. They ultimately did not know what was wrong with her. She did not remember anyone telling her to follow a bland diet and use antacids as needed. Tr.108. She recalled going to another hospital in Bakersfield almost immediately following her release, for the same heart-related symptoms. Claimant testified that it did not feel like a stomach problem. They did not tell her what was wrong. She stated that it did not feel like the same problem that sent her to Dr. Guevarra.[7] The problems that took her to Dr. Guevarra were different than those that took her to Antelope Valley Hospital in 1990. Tr.109-110.

On re-cross examination, Claimant stated she did not recall her doctors at Antelope Valley Hospital telling her that she had a possible reflux disorder. She did not recall telling the doctors at Mercy Hospital on March 24, 1990 that she had a history of "substernal epigastric area pain." Claimant stated that the pain feels "like it's in my heart. I feel like it's in my chest when I get sick and have to go to the emergency." Claimant continued "I just don't remember having those problems, you know, as being my stomach you're talking about." Claimant was not taking any medication when she had these problems in 1990. Tr.120-121.

Claimant testified that in January, 2000, the time of her last examination with Dr. DeFeo, she

[7]Dr. Loida Guevarra examined Claimant on October 6, 1999. Claimant presented with a chronic cough. At that time Claimant informed Dr. Guevarra that she had had an endoscopy several years prior, and had been diagnosed with gastroesophageal reflux disorder. Dr. Guevarra reported "a previous history of chest pain which subsequently has been detected to be non-ischemic in nature but related to her reflux disorder." See CX-9, p.4.

was taking Feldene[8] for inflammation, Flexeril[9] for muscles, Vicodin[10] for pain, and Reglan,[11] Nexium,[12] Pepto-Bismol and other over-the-counter-antacids for her stomach. Tr.49. On cross-examination, when asked why she was taking stomach medication six months before she first reported her stomach problems, Claimant stated that she was mistaken. She may not have been taking Reglan, Nexium, Pepto-Bismol and antacids in January 2000. Tr.106.

The next flare-up Claimant experienced was in 1999 or 2000. She described the incident as similar to a heart attack. She woke up feeling sick and went to the emergency room. "The symptoms were showing them basically that I was having a heart attack, so they did EKGs and all that, and they just eventually told me to quit taking my stomach medicine, or that medicine, it was really irritating my stomach." Tr.51-52. Claimant stated that she ceased taking one of the medications, Celebrex,[13] but could not stop taking all of it. This did not help her symptoms. Claimant stated that she has attempted to stop taking all of her back pain medication, and it did help with her stomach. However, she began taking the medication again because she "needed it." Tr.52-53.

On cross-examination, Claimant testified that the first time she noticed her gastrointestinal pain was when she went to the emergency room in 2000. She then stated that she had seen Dr. Guevarra approximately four or five months prior to that episode for stomach pain. She then agreed that her symptoms started around July, 2000. Claimant testified that she had been taking pain medicine and muscle relaxers since the day of the injury, October 5, 1998. Dr. Smith had given her Flexeril, Darvocet, Vicodin and Feldene. Dr. DeFeo continued Claimant on these medications.

On re-direct Claimant clarified that her visit to Dr. Guevarra occurred on October 6, 1999.

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[8]A nonsteroidal anti-inflammatory prescribed for the relief of pain and inflammation. *The Pill Book*, 7th ed., 1996, p.913.

[9]A muscle relaxant, prescribed for serious muscle spasms and acute muscle pain. *The Pill Book*, 7th ed., 1996, p.302.

[10]A narcotic-analgesic combination, prescribed for mild to moderate pain relief. *The Pill Book*, 7th ed., 1996, p.877-878.

[11]An antiemetic, or gastrointestinal stimulant prescribed for the treatment of gastroesophageal reflux disease, among other uses. *The Pill Book*, 7th ed., 1996, p.714.

[12]A compound that inhibits gastric acid secretion, prescribed for the treatment of heartburn and other symptoms of gastroesophageal reflux disease. *www.astrazeneca-us.com/pi203647NexiumPl.pdf*

[13]A non-steroidal anti-inflammatory, prescribed for relief of pain and inflammation caused by osteoarthritis and adult rheumatoid arthritis. *www.celebrex.com*. It is noted that this medication was not listed by Claimant as one she was taking at the time.

At that time she had a chronic cough and gastroesophageal reflux disorder. She was given Prevacid and other medication for her condition. Claimant stated further that the pain in her stomach had started five or six months prior to this visit. Tr.106-107. On re-cross examination, Claimant stated that the first time she visited Dr. Guevarra on October 6, 1999, it was for a routine mammogram, and not her stomach complaints. Claimant did not complain of any stomach pain at that first visit. Claimant recalled having an endoscopy in 1977, and had told Dr. Guevarra that she had been diagnosed with gastroesophageal reflux disease at that time. Claimant knew that she had had the condition since 1977, but stated "it stopped. I'd had no problems." Tr.118-119.

At the time of trial, Claimant testified that she was taking Nexium, Reglan, Pepto-Bismol and Rolaids for her stomach, and Darvocet,[14] Flexeril and another muscle relaxer, the name of which she could not recall, for her back pain. Claimant opined that her back medication is bothering her stomach, because she has tried to stop taking it, and her stomach "doesn't bother [her] as bad." Tr.54. Claimant testified on cross-examination that her gastroesophageal symptoms bother her every two or three days. Claimant did not recall testifying at her deposition that she experiences symptoms about once every two months, for two or three days at a time. Tr.121-122. Claimant asserted that over the course of the last year, "I can be sick one day for no reason, and the next day I'll be fine. I can be sick and be sick for a month. I can be sick once a month, once a week." Tr.122.

When the insurance company stopped paying Claimant's medical bills in January 2000, Claimant testified that for treatment, she would soak in her jacuzzi nightly, and her husband would rub her back for her. She continued to take muscle relaxers prescribed to her by Dr. John Chin, an internist. She testified that Dr. Chin has been prescribing medication for her for approximately a year and a half. Dr. Chin also prescribes stomach medication for her. Tr.54-55. On cross-examination, Claimant agreed that she first saw Dr. Chin in September 2000. She was not sure if anyone was prescribing medication for her from January 2000, her last visit with Dr. DeFeo, and September 2000, when she first saw Dr. Chin. She then clarified that she was taking medication that she had left over, she took some of her husband's medication, and some of her sister's medication during that time. Tr.80-81.

Claimant testified further, on cross-examination, that she returned to see Dr. DeFeo a year and a half later, on June 21, 2001. She did so to renew her prescriptions. Claimant was then not sure if Dr. Chin had been giving her pain medicine. She thought Dr. Chin had only given her Valium. Tr.82. Claimant denied returning to see Dr. DeFeo because she realized her case was going to be litigated. The reason she had not returned to him sooner was because she was taking other people's medication. Tr.83.

Claimant testified that Dr. Chin told her that her pain medication was upsetting her stomach, but he did not tell her to stop taking it. She further testified that her "gastrologist," Dr. Ramon Poola, and the people at the emergency room in September 2000, told her that her pain medication is causing her stomach troubles. Tr.56. On cross-examination, Claimant stated that at the emergency room,

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[14]An analgesic, prescribed for mild pain relief. *The Pill Book*, 7th ed., 1996, p.956.

she was told to stop taking the anti-inflammatory medication. She testified that this was not helpful. She had another flare-up of her gastrointestinal problem in January 2001. Tr.81.

Claimant saw Dr. Groden on November 6, 2001. Dr. Groden listed her current medications as Nexium, Prempro,[15] and Darvocet. Claimant stated that this was incorrect. She was, in fact, also taking Reglan, Flexeril, Valium and over-the-counter antacids. Dr. Groden's report notes a visit to the emergency room in Ridgecrest on November 22, 1995, for chest pain. Claimant had no recollection of this visit. Dr. Groden also noted a traffic collision in December 1986. Claimant stated that she was never involved in a car accident. Tr.110-111, RX-8, p.46.

Claimant's Back Injury:

Claimant testified that she had a back problem in the mid '70's, approximately 22 to 23 years prior to her current condition. At that time she pulled muscles in her back while trying to lift a trash can. Claimant could not recall how long she was out of work after that injury, but she speculated that she was in treatment for about three months, and out of work for possibly more than a year. Claimant asserted that her prior injury had fully healed. She had received no treatment for back pain since that time, until the October 5, 1998 injury. Claimant denied being in a car accident in 1986. Tr.49-50. On cross-examination claimant testified that it is possible that she was treated for a year for her back pain in 1977. Tr.71-72. Claimant believed that she had told Dr. Capen about her prior back injury. She then clarified that she does not recall if he asked about any prior back injury. "I'm not sure if I told him." Claimant stated that if he had asked, she would have told him about it. Tr.73.

Claimant was most recently sent to see Dr. Capen for her back pain. Dr. Capen recommended epidural injections, but Claimant refused because she is afraid to have them. Claimant stated that, as far as she knows, Dr. Capen has not released her from his care. He has not told Claimant that she is permanent and stationary because she refuses the epidural injections. Tr.87.

Claimant testified that she is still experiencing pain in her legs, as well as her back. The pain in her back "comes and goes." Some times, she experiences no back pain. The pain in her legs, mostly in the right leg, is "there most of the time," "usually every day." Tr.57, 70. On a good day, she has no back pain, but still experiences leg pain. She described this pain as "numb, tingly, just achy." On a good day, Claimant gave her leg pain a rating of three, out of a scale of one to ten, ten being the worst pain imaginable. Tr.57. On a bad day, Claimant described her leg pain as "throbbing, stabbing, burning, tingling." She gave it a rating of nine. Tr.61. Claimant avoids activities involving stooping, such as gardening, and vacuuming. Claimant stated that she has no problem standing. She then clarified that she cannot stand all day, and begins experiencing pain after about 15 minutes. Tr.58. Claimant testified that she avoids lifting anything heavy, such as bags of groceries. She feels comfortable lifting "ten pounds maybe." Tr.59.

Claimant stated that too much standing, lifting, bending, walking and riding in a car all cause her pain. She stated "I try to walk around the block at night and get about halfway around and get

[15]A type of estrogen, prescribed for the treatment of moderate to severe menopausal symptoms and prevention of postmenopausal osteoperosis. *The Pill Book, 7th ed., p.415-416.*

too tired and have to come back. My leg gets to hurting." Tr.59. She clarified that this would be on a bad day. She does not have as much of a problem walking on a good day. Tr.60. Claimant experienced weakness in her legs shortly after hurting her back. It felt like she "can't stand up on it very easily, can't walk very easily." When this happens, Claimant lays down. Tr.62.

Claimant still golfs. She testified that she does not carry her golf clubs though, she always uses a cart. Tr.59. Claimant has been playing golf for ten years. Before the injury of October 5, 1998, Claimant testified that she golfed seven days a week, and on weekends she would play as many as 36 holes. Golfing did not cause her any discomfort prior to her injury. Now, Claimant has to prepare for a day of golf. She begins by soaking in the jacuzzi the night before. She then takes half a pain pill before the game, and another half during. She will take a muscle relaxer as well. The most Claimant can golf now is three times a week. On one occasion, Claimant was able to go out and play another nine holes, three hours after her game of 18 holes. Tr.64-65.

On cross-examination Claimant agreed that she golfs approximately 100 times a year. When she golfs, she bends and twists at the waist. Claimant walks. Claimant denied playing on courses where she could not drive her cart out to her ball on the fairway. She did agree that she must walk to the green. Claimant testified that she does not carry her clubs to her car. Before Claimant owned her own golf cart, she would carry her clubs to the car if no one was around to help her. She testified that if she is alone, she will drive the cart to the car and lift her clubs into the car. Claimant testified that she can lift her own clubs, but that it bothers her. Tr.88-89.

The injury has also affected how well Claimant can play. She stated "you just don't play as good." Claimant still wins occasionally, but she is "also playing against people that are like 40 handicapped that don't play very good golf." Tr.66. On cross-examination, Claimant testified that the individual handicap in golf is supposed to even everybody out. Everyone's skill is accounted for. Tr.91. Claimant testified on cross-examination that she and her husband set up golf tournaments that take place approximately every three to four weeks. There were twenty-five separate events held between January 2000, and June 2001, the time in which she sought no treatment for her back. Some of the events are on back-to-back days. Claimant has won at least four of those tournaments since her injury. Tr.89-90.

Claimant testified that after her injury, she discontinued golfing for a period. She could not recall for how long, nor did she recall testifying at her deposition that it was for a period of one month. Tr.89.

Golf hurts Claimant's back and legs. After a game of golf, Claimant usually goes home, takes her medication and lays down for the rest of the day. She puts hot packs on her back, and uses her TENS unit. Tr.65-67. Claimant testified that none of her doctors have ever restricted her from playing golf. Tr.91. Claimant testified on re-direct that it takes about three and a half hours to play a round of golf. She further stated that, comparing physical demands, working is harder than golfing. She does not golf on a bad day. Tr.115. Claimant described her back pain on a bad day as "stabbing, burning, numb." She gave it a rating of eight to ten on a bad day. Tr.60-61. Claimant testified that

in the past month, she has experienced four, maybe five bad days. When this happens, she gets in the Jacuzzi and takes her medication. Tr.62.

On cross-examination, Claimant stated she experiences back pain "probably three or four times a month," or less than once a week. On re-cross examination, Claimant testified that golf hurts her back and her hips, but not all the time. "Sometimes it doesn't bother my back. Sometimes it does." When then asked the question "so, sometimes you go golfing and it doesn't bother your back at all?" Claimant responded "No. Usually it bothers me when I golf." Claimant was further asked "So which is it? You have back pain every time you golf, and that's two or three times a week, or you have back pain less than once a week? She responded "I have back pain usually every time I play golf." Tr.124.

At the time of the injury, Claimant's job title was "Recreation Aide." Claimant described her job requirements. She took tee times from customers, both over the phone and in person. Claimant cleaned the patio and the pro shop. She fetched golf carts if the "cart boy" was unavailable. She sold retail items in the pro shop, checked in orders delivered by UPS, and stocked the merchandise. Claimant stated that UPS would deliver merchandise every day, but the items delivered varied. On cross-examination Claimant stated that deliveries were not always a daily occurrence. Tr.93. On some days, usually once a week, the delivery included cans of motor oil for the maintenance crew. Claimant had to push these cases of oil out of the way until maintenance came to pick them up. Tr.26. Claimant testified on cross-examination that if she asked, the UPS driver would place these cases out of the way so that she did not have to "scoot" them herself. Tr.93.

Claimant was responsible for unpacking the boxes brought by UPS. These included boxes of golf balls, shirts, bags, shoes, and golf clubs. Claimant opined that the heaviest item she had to move was the box of "range balls." These balls were packaged loose in a large box. Claimant described the box as approximately 18 inches deep by 30 inches high by 18 inches wide.[16] Tr.28-29. Claimant stated that she had tried to lift that box, but could not. She would just "scoot it" out of the way, which involved bending over. A box of range balls would be delivered approximately every three to four months. Tr.29-30. Claimant further testified that the range ball machine was broken "most of the time" and Claimant would have to individually fill up a bucket of balls and hand it to the customers. Claimant testified that this required stooping over for the balls, as well as lifting. Tr.34-35.

Claimant testified on cross-examination that the bending she did at work was similar to the bending she does on the golf course, but when golfing, she does so without lifting at the same time. The golf clubs she unpacked from boxes were the same as the clubs she is capable of lifting out of her car. Claimant stoops on the golf course, as she did on the job, but without the weight. Tr.93-94.

Claimant disagreed with the job analysis of her position which stated that the heaviest item Claimant had to lift was a sixteen pound box of golf balls, and a seventeen pound golf bag. She stated "I did a lot more than that and a lot heavier boxes than that." Tr.95, RX-13, p.65. Claimant testified

[16]Claimant's testimony regarding the measurements of the box is somewhat unclear.

that if her employer offered her her old job, without all the bending, stooping and lifting, with a place to sit as needed, she would be able to do the job. She would not have left if they had offered her such accommodations earlier. Tr.67. Claimant testified that she would probably have worked at China Lake indefinitely, had she not injured her back. She had planned to continue working, even after relocating with her husband to Helendale, 100 miles away from the golf course.[17] Tr.68-69, 103-104. She had been commuting to Helendale on weekends for almost a year. Tr.68-69. On cross-examination, Claimant could give no reason why she had not asked her employer for her job back with accommodations. Tr.97.

Medical Evidence:

Claimant's Gastrointestinal Condition:

Dr. Jens W. Dimmick:

Dr. Jens W. Dimmick testified by way of post-hearing deposition, on behalf of Claimant. The deposition took place on Wednesday, March 13, 2002, at Lawndale, California. Dr. Dimmick is a board certified doctor of internal medicine. See Curriculum Vitae of Dr. Dimmick, CX-10. Dr. Dimmick examined Claimant on one occasion, January 7, 2002. He wrote two reports, dated January 7 and 10, 2002. See CX-10.

Claimant gave Dr. Dimmick a history of her condition, stating that she had been hospitalized in 1990 with chest discomfort that had been thoroughly evaluated. She further told Dr. Dimmick that subsequent to her 1998 injury, she had developed additional problems that caused her to go to the emergency room and have her medication changed. CX-13, p.7. Dr. Dimmick was shown the consultation report from Claimant's emergency room visit to Antelope Valley Hospital on February 12, 1990. The report stated "She describes it as a sensation of fullness and tenderness, which have been present off and on for four years but became particularly severe last night." It further read "symptoms of epigastric discomfort have been present off and on for four years." See CX-8, p.11. Dr. Dimmick did not think this inconsistent with what Claimant reported to him, but "it clarifies it. It shows that instance in 1990 was, in fact, a more severe episode that actually forced her to go to the hospital." Dr. Dimmick stated that he probably reviewed this document for his report. He did not have an opportunity to ask Claimant about it. CX-13, p.21-22.

On cross-examination, Dr. Dimmick stated that the history he gets from a patient is absolutely important. "In internal medicine, that's 99% of what you're dealing with, what you're working with." Claimant had neglected to tell Dr. Dimmick that she first experienced these symptoms twenty to twenty-five years prior. When asked if that fact was an important one to him, he responded that it

[17]Claimant and her husband bought a house in a planned community next to a golf course, 100 miles from her job, on August 16, 1998. Claimant permanently moved to Helendale on August 25, 1999. She was placed on temporary total disability by Dr. Smith on August 26, 1999. Tr.98-103.

would be important information to him. CX-13, p.21.

Dr. Dimmick reviewed records from Dr. Smith from 1998 and 1999, Dr. DeFeo from 1999 and 2000, Dr. Chin from 2000 and 2001, and the records from Antelope Valley Hospital from February 1990, as well as Desert Valley Medical Group in 1999, and Downey Orthopedic Medical Group in September 2001. Dr. Dimmick had subsequently received copies of Claimant's deposition, the trial transcript, and Dr. Paul Grodan's report. CX-13, p.7-8.

At the time of Dr. Dimmick's examination, Claimant's gastrointestinal complaints were epigastric pain which increased in severity several times a week. Claimant stated that she got some relief from this pain from Proton pump inhibitors.[18] Claimant also got some relief from motility regulators. CX-13, p.8-9.

Dr. Dimmick performed an electrocardiogram, pulmonary function studies, a chest x-ray as well as a physical examination. He found immediate tenderness in the upper part of the abdomen, mid-epigastric area. When pushing harder, there was involuntary guarding. Dr. Dimmick's diagnosis at the time of his deposition was that Claimant was suffering from inflammation in the upper gastrointestinal tract, secondary to gastroesophageal reflux. In layman's terms, Claimant was having acid percolating inside her chest from her stomach. CX-13, p.10-11. Dr. Dimmick opined that Claimant has an unknown-caused motility disorder, on top of which, she was taking non-steroidal anti-inflammatories that decrease the ability of the stomach to protect itself from its own acid. "Thus, with this extra acid, whatever muscle tone she had to keep acid out of her chest was minimized by the inflammation. And that allowed acid to run up and down freely, which gives her pain."[19] CX-13, p.10. Dr. Dimmick stated that his diagnosis was based upon what Claimant told him as well as the findings and records that he had. At the time of writing his first report, Dr. Dimmick did not have the benefit of Dr. Poola's report, but he thought that Claimant had told him that she suffered from a motility disorder. CX-13, p.28.

In his January 7, 2002 report, Dr. Dimmick's original diagnosis was that the swelling of the esophagus caused the motility disorder, which then led to the symptoms experienced by Claimant. See CX-10, p.8. After reading Dr. Poola's report, Dr. Dimmick changed his diagnosis, noting that the motility disorder was actually pre-existing.[20] The endoscopy showed a different type of motility

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[18]Proton pump inhibitors are used to heal stomach and duodenal ulcers, as well as relieve symptoms of esophagitis and severe gastroesophageal reflux. *www.bupa.co.uk/health_information*

[19]Dr. Dimmick explained that with a motility disorder the esophagus does not contract in a rhythmic fashion like it should. This disorder was what eluded doctors in 1990 at Antelope Valley Hospital, when they concentrated on Claimant's heart. CX-13, p.10-11.

[20]Dr. Dimmick did not review Dr. Poola's report until after he wrote his initial report on January 7, 2001.

disorder than he originally thought, given Claimant's history. He stated that "it was just kind of putting the cart before the horse and then putting the horse before the cart." The endoscopy report did not change his opinion as to causation, merely the order in which Claimant's condition had developed. "It just made a different formulation as to why she was having pain." CX-13, p.30-31. Dr. Dimmick did not think this new diagnosis was an important enough change to include in his supplemental report of January 10, 2002. CX-13, p.34-35.

Dr. Dimmick opined that it was not until the last year or so, when Claimant was taking anti-inflammatory medication, that doctors were able to properly diagnose Claimant's condition. The doctors at St. Mary's Medical Center on September 7, 2000 were the first to tell Claimant to stop taking the anti-inflammatory medication.[21] CX-13, p.11. Dr. Dimmick opined that in 1990, the doctors ignored Claimant's history of epigastric discomfort, and that it was probably Claimant's motility disorder causing her pain at that time. He agreed that it is sometimes difficult to differentiate between heart or chest symptoms and gastrointestinal complaints. "If they are in the chest, it's difficult. If it's in the colon, it's not difficult." If the symptoms are in the upper gastrointestinal area, "then you have to very carefully exclude one from the other." Dr. Dimmick opined that the complaints of chest symptoms in a 1995 report "were probably continued problems with her esophageal motility." CX-13, p.23.

Dr. Dimmick found nothing in Claimant's testimony that was inconsistent with his findings. He did not find Dr. Grodan's report consistent with his findings. Dr. Grodan's finding that the endoscopy was normal through the duodenum, and therefore there was no evidence of gastritis or irritation by Vioxx or Feldene was illogical. Dr. Dimmick explained that the changes from medication could have disappeared in the 48 hours it took to schedule and perform the endoscopy.[22] "These are evanescent things that occurred. The inflammation itself, the stomach turns over cells in the lining of the stomach a couple times a day. It doesn't take long to get rid of the inflammation. It doesn't take long to come back." Dr. Dimmick stated that in this case, Claimant had stopped taking anti-inflammatories several months before she had the endoscopy, thus the test did not show any abnormalities.[23] CX-13, p.14.

On cross-examination, Dr. Dimmick agreed that when gastric acid comes up into the esophagus repeatedly it causes damage. This type of damage can certainly be revealed in an

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[21]Dr. Dimmick testified on cross-examination that he did not know who had prescibed the anti-inflammatory medication to Claimant in or around September 2000. CX-26-27.

[22]Dr. Poola performed the endoscopy on March 13, 2001. CX-7, p.1-5.

[23]Claimant was told to stop taking the anti-inflammatory medication on September 7, 2000 at St. Mary Regional Medical Center. CX-5, p.6-7. Claimant testified that she did not stop taking the medication because the pain was too bad. Tr.52-53.

endoscopy. In this case, there was no evidence of hyperemia, or redness, no friability,[24] and no ulcerations, or holes. Dr. Dimmick agreed that there was no indication from that endoscopy of any damage to the esophagus which could have been caused by gastric acid. CX-13, p.40.

Dr. Dimmick was asked if Claimant's symptoms would continue after she stopped taking the medication. He opined that "unfortunately, the whole thing does not go back to normal real quick. The muscle that controls the acid's ability to escape up into the chest is still not quite working right . . . so it allows gastric contents to percolate back and forth."[25]

On cross-examination Dr. Dimmick opined that the reason Claimant continued to experience pain, so much that she had to return to the emergency room three times after discontinuing use of nonsteroidal anti-inflammatories, was due to "the compounding problem of pain and stress." Dr. Dimmick testified that Claimant had not actually reported that she was suffering from stress. She reported she was in pain, but the "stresses of pain" mentioned in Dr. Dimmick's report were his words, not hers. See CX-10, p.8, CX-13, p.36. Dr. Dimmick further stated that Claimant had not reported to him that she was having financial difficulties due to the accident, causing stress in her life, as he reported. See CX-10, p.8. Claimant told him that she was not working. He assumed that she was having financial stresses. CX-13, p.37.

Dr. Dimmick stated that as long as Claimant is suffering from the symptoms, she will require medical treatment. He further opined that the stress of Claimant's situation "adds another compounding and confounding factor; because the stress causes the stomach to make more acid." CX-13, p.15. Dr. Dimmick speculated that it may take anywhere from three or four years to ten years or more for Claimant's sphincter muscle to recuperate. CX-13, p.16-17. He opined that Claimant will require medication to try to reverse the process, to reduce the amount of acid being produced and keep the inflammation down. Claimant will also have to stay away from nonsteroidal anti-inflammatories and take other types of medication such as "Tylenol types of medication or narcotics." She will require medical monitoring as well. CX-13, p.17-18.

On cross-examination, Dr. Dimmick was asked why it took so long for Claimant's symptoms to begin. He responded that he had no idea. CX-13, p.28. Dr. Dimmick opined that Claimant's symptoms were brought on by her use of the medication in combination with the motility disorder and "this nebulous thing called stress." His explanation for her prior episodes, such as the one in 1990, was that Claimant was probably under stress at that time. "She might have eaten something that upset her stomach." He believed that her condition was attributable to stress, "[o]r chili or bad pizza or pepper." When asked if it was possible that the symptoms in September 2000 could be caused by pizza or chili or bad food, Dr. Dimmick responded, "Sure, they could have been. That's why you make recommendations and see what happens." CX-13, p.40-41.

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[24]Explaining friability, Dr. Dimmick stated "If you touch the surface, it doesn't break away. It stays the same. It bends, but it doesn't break away." CX-13, p.39.

[25]This muscle is called the lower esophageal sphincter. CX-13, p.15.

Dr. Paul J. Grodan:

Dr. Paul J. Grodan testified on behalf of Employer, by way of post-hearing deposition. The deposition took place on Friday, March 22, 2002, at Beverly Hills, California. Dr. Grodan is board certified in internal medicine. See Curriculum Vitae of Dr. Grodan, RX-21, p.253-254; RX-23, p.5-6.

Dr. Grodan examined Claimant on November 6, 2001. He wrote a report, dated December 13, 2001. See RX-8. Claimant reported that she experienced a reflux of regurgitational food, what she referred to as an "acid feeling" or "gastric problems." Dr. Grodan described Claimant's complaints as very non-specific. Dr. Grodan took a complete history from Claimant. She reported the onset of the acid feeling twelve years ago, or about 1989. RX-23, p.7-8.

Dr. Grodan performed a physical examination and found "really nothing." Dr. Grodan performed laboratory tests. He opined that there was one significant negative result. Claimant's helicobacter pylori antibody was negative. He explained that this was significant because if it had been positive, that could explain her gastric complaint, as an infection in the stomach, but Claimant did not have one. RX-23, p.8-9.

Dr. Grodan reviewed Claimant's past records, including the records regarding an endoscopy performed by Dr. Poola on March 13, 2001. Dr. Poola's records confirmed that Claimant had been complaining of epigastric pain on and off for eight years, but Claimant claimed it was worse in 2000.[26] RX-23, p.10. The records also showed Claimant had an angiogram of her heart in 1990, which was normal, ruling out coronary disease. Dr. Grodan stated that the records from St. Mary's Hospital in 2000 referenced Claimant had reported reflux symptoms for over a period of ten years. Dr. Grodan did not recall Claimant telling him her symptoms began twenty to twenty-five years ago. This information would not have changed his opinion, however. RX-23, p.10.

On cross-examination, Dr. Grodan was asked about Claimant's extended hospital stay in February, 1990. At that time, Claimant had complained of epigastric pain, tenderness, and chest pains. The doctors concentrated on Claimant's cardiac condition because Claimant had an abnormal EKG. Dr. Grodan stated that they did address the problem of reflux esophagitis, to rule out peptic ulcer disease. He opined that the symptoms for both conditions are similar. Chest pain and belly pain can both refer to a heart problem as well as a stomach problem. Dr. Grodan noted a frequent reference to Claimant's reflux and gastroesophageal problem in the reports, but could not be sure if the doctors did an endoscopy, or other tests at the time. Claimant was more probably than not, kept in the hospital to rule out a cardiac problem. RX-23, p.26-29.

[26] Claimant was admitted to the hospital in February and March 1990 for cardiac and gastric complaints. Claimant was admitted in November 1995, for atypical chest pain with a history of gastroesophageal reflux.

On re-direct, Dr. Grodan noted that in the discharge notes from the February 1990 hospitalization, Claimant was scheduled to have an esophagogastroduodenoscopy[27] as an outpatient. See CX-8, p.36. Dr. Grodan was then shown the report from Mercy Hospital on March 24, 1990. Claimant was complaining of a history of lower substernal epigastric area pain, left shoulder and arm pain, nausea and weakness. The report further states that Claimant went to Palmdale Antelope Valley, and had an upper GI endoscopy, which was negative. Claimant reported that she was told that she may have esophagitis,[28] but reported nothing of a motility disorder. RX-23, p.35-36, 41. Dr. Grodan stated that it is not clear by this report whether the motility disorder was present or not at that time. He would have to see the actual endoscopy report to be sure. RX-23, p.41.

On cross-examination, Dr. Grodan opined that one will never really know whether these complaints, off and on over the years, were cardiac or gastrointestinal. "She can't tell you, and I don't think anybody else can." RX-23, p.31. On re-direct, Dr. Grodan explained that "unfortunately, the same type of pain can cause two or three different conditions." RX-23, p.32.

Dr. Grodan's diagnosis was, that based on Dr. Poola's report of Claimant's endoscopy, Claimant suffered from an esophageal motility disorder.[29] Claimant did not have gastritis, duodenitis, nor esophagitis, as the endoscopy showed no mucosal changes. Dr. Grodan explained that because of the motility disorder, the esophagus is more likely to regurgitate because the sphincter does not work very well. "So your gastric contents can go up to the esophagus, and that's what may have been happening. But if your motility is affected, we only get a feeling like you're going to be regurgitating the food because the food can hang in the esophagus." RX-23, p.13. Dr. Grodan noted that the endoscopy did not reveal any damage done by medications. RX-8, p.47. Dr. Grodan explained that if a patient took an aspirin or non-steroidal anti-imflammatory such as Feldene, "even one pill can sometimes give you a little bit of an erosion of the mucosa. So if you look with an endoscope on the mucosa, you could see spots of erosion." If a patient was producing a great deal of acid from stress or for some other reason, then the inflammation, or the gastritis, would be visible in the esophagus.[30] Claimant had a normal mucosa. "If she had anything to explain her symptoms, you would see the changes [in the mucosa]." RX-23, p.14-15.

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[27]An endoscopic examination of the esophagus, stomach and duodenum. *Dorland's Illustrated Medical Dictionary*, 28th ed., p.581.

[28] An irritation of the esophagus lining by acid. Rx-23, p.40.

[29] Dr. Grodan explained what a motility disorder is. There is a coordinating motility that helps food move down the throat. This undulation keeps food moving in one direction. Motility exists in the esophagus, as well as the small bowel and colon. During an endoscopy, the doctor can see the motility occur. Claimant did not have that motility during her endoscopy. There was no contraction, no motility. RX-23, p.12.

[30]Dr. Grodan opined that this disorder is not a condition related to stress or that can be aggravated or accelerated by stress. See RX-8, p.47. The "gut" is controlled by the autonomic nervous system. In the esophagus, "[t]here is no target tissue that stress will affect, because you don't have any other endings there that stress will affect. It's controlled by the vagus nerve, and that's the nervous part of the autonomic system." RX-23, p.13-14.

Dr. Grodan opined that Claimant's motility disorder was "absolutely not" caused by or aggravated by the October 5, 1998 injury, or subsequent use of medication. It "[c]ouldn't be. There is no mechanism for it." On cross-examination, Dr. Groden opined that anti-inflammatory medication can cause damage to the stomach. It can cause erosion of the mucosa, bleeding and ulceration. When medication is withdrawn, complete healing is expected to occur. Depending on the degree of erosion, it may leave a scar. He continued, that if there was enough damage to cause symptoms, then "you should see some scarring." Rx-23, p.30.

Dr. Grodan reviewed Dr. Dimmick's report. Dr. Grodan stated that Dr. Dimmick's report does not accurately reflect Claimant' history of her complaints. Dr. Dimmick implies that she had one attack twelve years ago, and nothing until the present. The records indicate otherwise. This is significant, in that it does not accurately represent what the facts were. Dr. Grodan disagreed with Dr. Dimmick's number one diagnosis, gastroesophageal motility disorder, secondary to gastroesophageal reflux. He opined that "there is no way in the world that reflux can give you a motility disorder." He continued, "[i]t can give you inflammation or esophagitis. It can give you erosion of the esophageal mucosa. It can give you changes. . . But it's not going to affect the motility, because the reflux is not going to affect what's inside the wall of the esophagus." RX-23, p.16-17.

Dr. Grodan agreed with Dr. Dimmick's revised opinion insofar as he recognized that the motility disorder was pre-existing. He did not agree with Dr. Dimmick's theory that the reflux did anything. "You can't weaken the esophageal muscle by reflux." There is no evidence in the endoscopy of any inflammation. Dr. Grodan stated that one can argue, as Dr. Dimmick did, that at the time of the endoscopy Claimant did not have any inflammation, but if a patient "has a chronic problem where you always have reflux, and what was going on in her case for a dozen years, the endoscopy, even though it's a look in time, should still pick up something abnormal, and it did not." RX-23, p.18-19.

Dr. Grodan opined that if one were to accept Dr. Dimmick's opinions with respect to causation and the use of anti-inflammatory medication, then Claimant's symptoms would have arisen in a matter of days. Furthermore, if Claimant had stopped taking the pills, the symptoms would have gone away. Rx-23, p.20. Claimant's complaints of symptoms one year or two years after she began taking the medication are inconsistent with Dr. Dimmick's diagnosis. "The timing is wrong." Dr. Grodan stated that Claimant had symptoms, on and off, for at least a dozen years, and will continue to do so for a dozen more, because she has a pre-existing motility disorder. "Regardless of medications, regardless of whether she works or not, regardless if she has any injuries, she will have those symptoms." RX-23, p.21-22.

Claimant's Back Injury:

Dr. Don DeFeo:

Dr. Don DeFeo, a neurosurgeon, did not testify at the hearing in this matter. His medical reports are found at CX-2, p.1 through 18. Claimant was referred to Dr. DeFeo by Dr. Tom Smith[31] for his input regarding further diagnostic tests, treatment and possible surgery. See CX-1, p.4, 8.

At his first examination on March 4, 1999, Dr. DeFeo took a short history[32] from Claimant, and reviewed an MRI, the date of which was not specified.[33] At the time, Claimant was complaining of a five-month history of progressively severe low back pain and bilateral leg pain, right worse than left. Dr. DeFeo reported that the MRI showed "degenerated, dehydrated flattened L5-S1 with reactive formation of the bone at L5 and S1." There was "minimal herniation of 1-2 mm." CX-2, p.1.

Dr. DeFeo's findings were straight leg raising pain on the right at about twenty degrees referred to the right buttock and low back, and on the left at about forty degrees referred to the right. He found some sensory loss on the dorsum of her foot, weakness in the extensor hallucis longus, and in the extensors of her right foot.[34] He reported: "All in all the patient has a right L5 radiculopathy probably secondary to an unstable joint at 5-1." D. DeFeo recommended a myelogram CT with weightbearing flexion/extension films, and an EMG of the right leg, "since this pain is progressing and ruining the quality of [Claimant's] life." CX-2, p.1-2.

On April 23, 1999, Dr. DeFeo wrote a report regarding the results of Claimant's myelogram. The myelogram showed "degenerative changes at 5-1. No major defects, a 2mm encroachment with flexion/extension. Her EMG is normal. She probably has an unstable degenerative joint at 5-1. She may need discograms." CX-2, p.5. Dr. DeFeo noted in a report dated June 8, 1999, that he spoke with Claimant about the procedure, and she was not sure that she wanted to proceed. He recommended that Claimant obtain a custom fabricated TLSO brace,[35] which would offer "both therapeutic and diagnostic results." CX-2, p.8.

On June 19, 1999, Dr. DeFeo stated in a letter to Scott Newton of Contract Claims Services that he believed Claimant could return to her usual and customary occupation once she had been fitted for her TLSO brace. Dr. DeFeo felt that after Claimant had had an opportunity to

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[31]Dr. Tom Smith, and orthopedic surgeon, was Claimant's first treating physician. Claimant was referred to an orthopedic surgeon by Dr. Hammond, at NAWS dispensary. CX-1, p.1.

[32]Dr. DeFeo reported that Claimant had had no serious illnesses, and no bad accidents. CX-2, p.1.

[33]The Court assumes that this MRI was the one taken on December 13, 1998, as there is no record of any other scan taken between that date and the date of Dr. DeFeo's first examination.

[34]Extensor is a general term for any muscle that extends a joint. Hallucis refers to the great toe of first digit of the foot. Longus refers to a general term denoting a long structure, as a muscle. *Dorland's Illustrated Medical Dictionary*, 28th ed., p.594, 730, 959.

[35]Thoracic lumbar sacral orthosis. *Medical Abbreviations*, 8th ed., p.252.

wear the brace for a three to four week period, he would be able to make a determination as to whether Claimant had reached maximum medical improvement. CX-2, p.9. Claimant was scheduled for a fitting for the brace on July 26 and 27, 1999. CX-2, p.10.

In a report date October 13, 1999, Dr. DeFeo stated that Claimant's pain was "about the same, a little worse probably." He stated that the brace was helping somewhat, but he recommended an epidural injection to the L5-S1 area. If this procedure did not improve Claimant's condition, Dr. DeFeo recommended a stabilization at the L5-S1 joint. Dr. DeFeo requested authorization for the epidural injection, and scheduled a follow-up examination in two weeks. CX-2, p.11.

Dr. DeFeo's next report is dated January 18, 2000. At this point, Dr. DeFeo reported that Claimant was complaining of right leg spasms and constant sciatic pain when lying down. She quit her job because the pain was intolerable. Dr. DeFeo's findings upon examination were residual low back ache, no straight leg raising pain and adequate strength in all muscle groups. Reflexes were 2+ and symmetrical. Dr. DeFeo found the "findings [were] consistent with the injury claimed by [Claimant]." Dr. DeFeo diagnosed lumbar spondylosis with an occasional radiculopathy. Claimant was still symptomatic from an L5-S1 disc space. "She probably has some micro instability at that joint. She is without neurologic deficits. Her pain is tolerable as long as she is not working." Dr. DeFeo released Claimant to light duty. CX-2, p.14.

In a letter dated March 21, 2000, Dr. DeFeo stated that "[Claimant's] films showed degenerative changes of a small herniation at L5-S1. There is no evidence that this is a congenital problem." Dr. DeFeo felt that Claimant's injury had to be considered work-related because until October 1998, Claimant had a negative history of back pain and was asymptomatic. CX-2, p.17.

Dr. Daniel A. Capen:

Dr. Daniel A. Capen testified on behalf of Claimant by way of post-hearing deposition. The deposition took place on Thursday, February 14, 2002, at Downey, California. Dr. Capen is a board certified orthopedic surgeon. See Curriculum Vitae of Dr. Capen, CX-12, Exhibit 1. Dr. Capen testified that he has seen Claimant on numerous occasions, beginning with his first examination on September 20, 2001. CX-12, p.7, 9. On cross-examination, Dr. Capen clarified that he examined Claimant three times. Dr. Capen's reports are marked as CX-3. CX-12, p.29.

Dr. Capen testified that he treated Claimant for an injury occurring on October 5, 1998, in which Claimant was lifting a box in a bent-over position. She felt a pull in her back when she lifted the box. Claimant reported that the symptoms worsened over the next few hours. She tried to continue working, "but did report the injury and got medical attention that led to numerous evaluations and treatment from 1998 up to and including when she started treating with me." CX-12, p.7. On cross-examination, Dr. Capen stated that he did not know at the time of the initial examination that Claimant had not received any treatment between January 2000 and June

2001. He continued: "I am aware of that from review of the medical records, yes." He could not recall specifically asking Claimant why she had not sought treatment during that time. Dr. Capen opined that this gap was consistent with Claimant's wishes to avoid surgery "because DeFeo's notes [in his final report in January 2000] are he couldn't do anything more for her other than surgery." It was Dr. Capen's understanding that Claimant came to him because the pain was worse. CX-12, p.31-32.

On re-direct, Dr. Capen stated that there is evidence in Claimant's trial testimony that she was getting pain medication from some source during this period. This may suggest how Claimant was able to go without treatment for a year and a half. The inference to be made from this is that Claimant was not going without treatment for a year and a half, "I mean, medication is treatment." CX-12. p.81-82. On re-cross examination, Dr. Capen agreed that he had not seen a single medical record from that year and a half time period, nor had he seen a single prescription slip for that time period. CX-12, p.90.

Summarizing Claimant's treatment prior to seeing him, Dr. Capen testified that Claimant was initially given medication and physical therapy, as well as some diagnostic x-rays. She was taken off work for a very short period of time. She had a consultation with Dr. DeFeo, who performed an MRI scan. Dr. DeFeo recommended surgery.[36] Claimant did have periods where she benefitted from the therapy. Claimant stopped work in 1999. She began to get pain in her upper back and neck area. Claimant wanted to avoid surgery, "but the diagnostic studies that were done before, plus the mechanism of trauma, plus plane x-rays showed that she had significant disc sclerosis and abnormality at L5/S1, as well as a bit of abnormality at the C5-6 disc."[37] CX-12, p.8.

Claimant's complaints at the time of the first examination were both lower and some radiating upper spine pain, which worsened with activity. She described some numbness and tingling into the lower legs. Bending and twisting as well as prolonged sitting aggravated the pain. Claimant could not sit, or stand and walk, for more than ten to fifteen minutes without an increase in pain. Her pain was worse at the end of the day than at the beginning. Claimant's complaints were consistent with Dr. Capen's findings, as well as the studies. CX-12, p.11. Dr. Capen testified on cross-examination, that his understanding of how often Claimant experiences back pain was "most, if not all of the time, was what she represented to me when I first saw her that it was there, sometimes worse; sometimes better." This would be inconsistent with Claimant's testimony that she experiences back pain three or four times a month. CX-12, p.55-56.

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[36]Dr. Capen testified on redirect that based on Dr. DeFeo's records, and without speaking with him, it is a certainty that Dr. DeFeo was recommending surgery based solely and totally on the effects of the October 5, 1998 injury and not at all on any degenerative condition Claimant might have. CX-12, p.87.

[37]The remainder of the facts will exclude any testimony regarding Claimant's cervical spine, as Claimant has withdrawn that claim. See fn.5, *supra*.

On cross-examination, Dr. Capen was asked if Claimant had complained of leg pain without the presence of back pain. Claimant had reported tingling, and numbness in her legs, but Dr. Capen could not recall reviewing anywhere that Claimant had reported leg pain without simultaneous back pain. CX-12, p.35-36. Dr. Capen explained how it would be possible to experience leg pain without simultaneous back pain:

> The disc is richly innervated. The sensory nerves from the disc go to the same nerve root that sensory innervation from the legs come from, and it's much like a heart attack causing pain down the left arm. It's a referred pain pattern, so people can have disc annular tears, disc degeneration, mechanical problems with the spine, and feel leg pain, but do not have anything that's actually touching the nerve root causing radiculopathy. CX-12, p.35.

Dr. Capen performed an examination of Claimant at the initial visit. He had some records to review at that time. He had the records of Dr. Thomas Smith, Dr. DeFeo, the previous MRI scan from September 1999, records from Orange Coast Neuromedical, and a report from Dr. London. The opinions of Drs. Smith, DeFeo and Hammond[38] were consistent with what he found. On cross-examination, Dr. Capen testified that at the time of his first examination, he did not have any medical records to review. They were provided later. CX-12, p.29.

Dr. Capen testified on cross-examination that he took a medical history from Claimant. A medical history is important to a physician "because you rely on the history to formulate a great deal of your diagnosis." Claimant had not reported to him that she had suffered a back injury in the 1970s which required her to seek treatment for up to a year. Dr. Capen agreed that this would be a significant injury. CX-12, p.33. On cross-examination, Dr. Capen was asked whether he thought it important to examine a patient at or around the time of the initial injury, as opposed to three years later. He did not. He stated that "if medical records are available, and if the historian is reliable, no, it doesn't factor in to a conclusion someone would make when seeing a patient for a first time after the injury, otherwise doctors wouldn't be able to see somebody unless they were there at the time of the injury." "One relies upon history and other medical information, and the reliability of doctors to make conclusions after the fact." CX-12, p.30.

Dr. Capen's diagnosis was lumbar discopathy,[39] and a spinal sprain/strain syndrome. By this, he meant that "[Claimant] had a chronic injury to her back, causing damage not only to a disc, but the muscles and the ligaments." Claimant suffered from moderate degenerative changes in her lumbar spine. CX-12, p.11-12. Dr. Capen opined that "these would be changes that reflect

[38]Dr. Capen was referring to the report from Claimant's examination on October 6, 1998, the day after the injury occurred.

[39]Dr. Capen explained that discopathy means that Claimant had damage to a disc. "Whether or not it's an annular tear, we haven't proven, but where there is disc insufficiency and disc pathology, that is a pain producer." This diagnosis can incorporate degenerative conditions stemming from an injury. CX-12, p42.

repetitive type activities, and could, in part, reflect age, although not all of them." Dr. Capen knew of no prior history of back injury prior to October 5, 1998. But Claimant had a job "that involved repetitive use, but she could not recall, at the time of my initial visit, any substantial injuries either related to sports or accidents or traumas." CX-12, p.13. On cross-examination, Dr. Capen testified that the degenerative changes seen in the lumbar spine are changes which could be caused by repetitive type activities, such as golf. CX-12, p.76.

Dr. Capen found some loss of spinal mobility. Claimant had difficulty with bend and rotation of the spine. She did not have any extension whatsoever, which, Dr. Capen opined, is abnormal, and goes along with significant disc injury. There was no evidence to suggest specific nerve root deficit, but straight leg raising produced pain bilaterally. There was no appreciable atrophy of the leg muscles. X-rays taken in the flexed and extended position showed some hypermobility at the L5/S1 disc, along with the disc collapse. CX-12, p.9-10.

Dr. Capen testified on cross-examination that hypermobility can be in response to degeneration, or "in response to an injury to the disc where the annulus is torn, and it is not a sufficient disc." Regarding this annular tear, Dr. Capen stated: "we haven't done a discogram, but I would be astounded if the L5/S1 disc was not a pain generator, and was not positive with a leak and an easily demonstrable annular tear." CX-12, p.72. Dr. Capen opined that it was "overwhelmingly likely" that the annulus was torn in Claimant's case. When asked if this was demonstrated on the MRI scan, Dr. Capen stated that "it's rare to be able to see disc annular tears other than doing discograms." In this case, he did not recommend doing a discogram because Claimant did not want to undergo surgery. CX-12, p.40-41. On re-cross examination, Dr. Capen stated that he believes that the tear of the annulus, caused by the October 5, 1998 injury, ultimately led to the hypermobility. CX-12, p.91-92.

On cross-examination, Dr. Capen was asked about his notation that "maximum effort on motion testing was difficult to determine." Dr. Capen explained that Claimant's extension was limited by pain. "I didn't bend her over to see if there was an ability to extend. She just reported pain and had an inability to do it. The rest of the range of motion, she was clearly exerting effort."[40] CX-12, p.38. Flexion was fifty degrees, rotation to both left and right was twenty degrees, tilt to both left and right was thirty-five degrees. See CX-3, p.4. Dr. Capen opined that normal flexion would be fifty degrees. Normal rotation and tilt would be thirty to forty degrees. CX-12 p37.

Dr. Capen ordered an MRI of the low back, and electrical studies of the lower extremities. These showed Claimant "had some left-sided nerve root irritability that was either a peripheral type nerve irritation, or a sign of some mild irritation at the spine level in the low back." On cross-examination, Dr. Capen stated that the EMG studies did not directly show anything related to the October 5, 1998 injury. There was no lumbar radiculopathy. CX-12, p.46. A peroneal

[40]Dr. Capen stated that rotation right and left, twisting at the waist, one of the range of motion tests, is similar to the activity involved in a golf swing. On the back swing you rotate right, and on the forward swing, you rotate left, if you are right-handed. CX-12, p.38.

neuropathy, as indicated on the EMG, could be caused by an excessive plantar flexion injury or from wearing high heels. These are two possibilities, but to Dr. Capen's knowledge, Claimant has never had a plantar flexion injury, and he has never seen Claimant wearing high heels. CX-12, p.49. The L5/S1 changes on the MRI were also visible on the x-rays. These studies confirmed what he had found in his examination. CX-12, p.10.

On cross-examination, Dr. Capen was asked if the MRI scan he ordered showed that the abnormalities at L5/S1 were all degenerative in nature. He responded that "by the time that scan was done, yes, they were degenerative in nature." It showed no evidence of either spinal cord impingement nor nerve root impingement. It did show foraminal narrowing. CX-12, p.50-51.

Dr. Capen testified that his impression, from Claimant's description of her job duties, was that her job was "on the relatively vigorous side of occupational requirements." He would not agree with Claimant's characterization of her job as light, "if what she was telling me was a true representation of her job." After looking over the "official description" of Claimant's job, RX-13, Dr. Capen found some tasks to be light, but he still felt that "if you look at all of the tasks required, that it is not totally a light job." He opined that the tasks most stressful to the spine would be stocking merchandise above shoulder level, cleaning the pro shop, carrying golf bags and clubs, marshaling on the golf course, driving a golf cart for protracted periods of time,[41] and "the actual performance that she described to me of occasionally playing golf would be some [tasks] that would be most frequently stressful to the spine." CX-12, p.16-17.

Dr. Capen would not want to see Claimant return to the job if it included the activities he mentioned. Claimant could do the parts of the job that involve the office/pro shop work, cashier, taking start times, and ordering equipment. "I would severely limit or delete the marshaling on the golf course, and while as a recreation, I don't think golf is a terrible event for someone to do if they enjoy it once in a while, I would not like to see [Claimant] doing that as a requirement because of the stress to the upper and lower spine." CX-12, p.18. It would also be prudent to provide her with a stool so she could sit and stand at her discretion. CX-12, p.19.

At the time of the last visit, January 7, 2002, Dr. Capen found Claimant permanent and stationary, because she refused to proceed with epidural injections. There was nothing more Dr. Capen could do for her. CX-12, p.56-57. Dr. Capen restricted Claimant to light work. She should avoid bending, twisting, lifting, and other like activities that stress the spine. He did not specifically restrict her sitting, standing and walking requirements, because Claimant stated that she could regulate that on her own. Dr. Capen recommended that Claimant swim on a regular basis, do stretching exercises, and take anti-inflammatory medication. If things worsened, she should come back and they would consider more invasive treatment such as surgery. CX-12, p.21-22.

[41]Dr. Capen explained that the driving on variable terrain, such as at some golf courses where players drive on the fairways, would cause bouncing and vibration, placing more stress on the spine. CX-12, p.17.

Dr. Capen had recommended surgery, because the injury was in 1998 and the pain continued through 2002, and he felt that "surgery was one of the only things that had a likelihood of substantial improvement of her condition." He contemplated "complete removal of the disc, decompression of all the bone spurs, and fusing that segment to stop any mobility whatsoever in that segment." He also recommended epidural injections, prior to surgery in hopes that it would work, "if someone were willing to have invasive treatment." Dr. Capen has left these ideas in the future, because Claimant has "maintained a desire to avoid these things." CX-12, p.22-23.

Dr. Capen opined that, in the future, Claimant's condition will most likely remain the same, with mild fluctuations and flare-ups. "There's a minimal chance that it would improve, and there's a reasonable chance, say twenty to twenty-five percent, that it will deteriorate to the point where eventually she will perceive the cure as better than the disease." He did not think it ever advisable to change her work restrictions because he thought doing those activities on a regular basis would precipitate a worsening scenario. If Claimant were to go back to work and ignore his restrictions, there is a fifty percent chance, or greater, that she will worsen. CX-12, p.23-24. On cross-examination, Dr. Capen stated that Claimant would have a twenty-five to thirty percent chance of worsening if it is true that she golfs two to three times per week, and does not stick to his restrictions. Dr. Capen then stated that playing golf with that frequency increases the likelihood of worsening of Claimant's lumbar spine condition. CX-12, p.78.

Looking at Dr. London's report of October 13, 1999, Dr. Capen agreed that Claimant had a lumbar strain, but disagreed with his conclusion that Claimant was capable at that time of her usual work in total, and not in need of any additional treatment. He further disagreed that no work restrictions were indicated as a result of the October 5, 1998 injury. He disagreed that Claimant should not undergo epidural injections. He disagreed with Dr. London's finding that "the L5/S1 disc is narrowed based upon solely the development of the aging process throughout her adult life." CX-12, p.26. Dr. Capen testified that Dr. London mentioned that Claimant had a back injury fifteen years previously, but there is no mention of any ongoing treatment or continuous injury, "so it's my opinion that some of the changes that we see now, all of her symptomatology and the disc dysfunction itself, are due to the trauma that occurred when she got hurt." CX-12, p.27. On cross-examination, Dr. Capen opined that a lumbar sprain/strain takes three months or less to heal. CX-12, p.70.

Regarding Claimant's golfing, Dr. Capen testified that if she is to do so on a regular basis, he would recommend that she do warm-up exercises, and "that a modification in accordance with her symptomatology be heeded. In other words, if she were organizing a golf tournament, yes, swing the club a little bit. If it starts to hurt, drop out. Play a few holes, rest a few holes, things like that." CX-12, p.19. It was Dr. Capen's understanding that, prior to the October 5, 1998 injury, Claimant played golf "several times a week, in a month. There was no restriction in her ability to play golf." When Dr. Capen mentioned the surveillance films to Claimant, she mentioned to him that her playing was substantially reduced after the injury. She mentioned that her swing was not as good, and that it was painful to play, but Dr. Capen did not know the number of times a week she played. CX-12, p.20.

On cross-examination, Dr. Capen was asked about the statement in his report on the surveillance videos, "These activities depicted on the film may not be in her best interests." Dr. Capen explained that knowing her condition, "I would say that any rotational activities, on a repetitive basis, should be done with caution." Dr. Capen's understanding of how often Claimant played golf was "occasionally. I don't have the number of rounds she has played at either partial or complete." Dr. Capen stated that two or three times a week or one hundred to one hundred and fifty times a year, hypothetically speaking, would be substantially more than "occasionally." CX-12, p.60-61. Dr. Capen testified that he did not see any type of pain avoidance behavior on the films. This did not change his medical opinion, however. He stated "Those films are taken four months apart, and in and of themselves, absent your hypothetical, do not change my opinion expressed in my report." CX-12, p.62.

If Claimant was playing golf two or three times per week, as in the hypothetical, Dr. Capen stated that would change his medical opinion. When asked how, Dr. Capen stated that he would still restrict Claimant from very heavy work, but "it would make that job much more easily modifiable to suit her condition." He would still not like to see Claimant lifting from foot to head. She could lift seventeen pounds though. He would still limit the amount of time Claimant would have to marshal.[42] He would still recommend a stool for occasional sitting, "but I don't think I'd limit anything else that I saw in those job descriptions." CX-12, p.62-64. On re-direct, Dr. Capen stated that if Claimant is golfing on a continuing basis, regardless of whether she is now golfing half as much as she did prior to the accident, "it would make it less necessary to preclude her from as many things as I stated in her job description. It would, to me, signify that at least her back is able to tolerate some forms of stress that, prior to these hypotheticals, I thought it would be unable to withstand." CX-12, p.78.

Regarding Claimant's taking medication in order to be able to play golf, Dr. Capen opined on re-direct, that one might not get an accurate impression of Claimant's physical capabilities if she were acting with the benefit of pain medications. CX-12, p.80. If Claimant is playing golf two to three times a week using pain medication, then the work restrictions would be closer to what Dr. Capen originally articulated. CX-12, p.81.

On cross-examination, Dr. Capen was asked if he believed that Claimant's golf activities, during the year and a half without treatment, had any effect on the anatomical structures in her lumbar spine. He responded "Yes." He continued: "It would produce wear and tear, especially on a damaged disc such as the L5/S1 disc." It would account for the increased narrowing, hypermobility, radiation of pain up the spine, "all of the above." CX-12, p.66. However, Dr. Capen still did not think that Claimant's October 5, 1998 injury had fully healed. He thought the most likely thing was that after Dr. DeFeo recommended surgery, which Claimant did not want, she returned to playing golf. She had not, however, fully recovered, and golfing exacerbated her

[42]Marshaling consists of "driving around in a golf cart, on unlevel terrain, bouncing around going from place to place to make sure that the groups are not making a five-hour round." If Claimant could get out every three or four minutes, and move around like when playing golf, this would be better.

condition to the point where she had to return to the doctor. He stated: "here's a person who was scared of surgery and stayed away from doctors for a period of time, but I think it's overwhelmingly likely that [her back] was still symptomatic." CX-12, p.67.

Dr. Capen opined that playing golf prior to 1998 would have constituted a cumulative trauma, but there was no way of knowing how long it would have taken for that cumulative trauma to become symptomatic. Claimant's current symptoms stem from the October 5, 1998 injury. Dr. Capen opined that two-thirds of Claimant's current degenerative condition is a result of the original injury, and one-third is the result of her golfing two to three days a week. CX-12, p.84.

Dr. James T. London:

Dr. James T. London testified on behalf of Employer by way of Post-Hearing deposition. The deposition took place on Thursday, February 28, 2002, at San Pedro, California. Dr. London is a board certified orthopedic surgeon. See Curriculum Vitae of Dr. London, RX-20. Dr. London examined Claimant on two occasions, October 13, 1999, and December 10, 2001. RX-22, p.6-7, 22. Dr. London wrote two reports which are contained in RX-7.

At the time of the first examination, Claimant reported that while lifting boxes on October 5, 1998, she felt a sharp sudden pain in her low back. Claimant was stooping and turning to move the boxes at the time. Claimant's physical complaints were frequent low back pain radiating into the right buttock and down the anterior and lateral aspects of the mid-third of the right thigh. The pain was associated with pain in her right forefoot, all the toes, and the top of her right foot. Claimant reported that the pain was worse when lying down at night, or standing for a prolonged period of time. It was worse with leaning backward or siting a long time. It improved if she changed positions often. Claimant had frequent tingling in all her toes on the right foot, and occasional aching in the left forefoot. Claimant did not complain of any radiating pain, numbness or tingling in the left lower extremity. RX-22, p.7-8.

Dr. London took a history from Claimant. She reported a low back muscle strain fifteen years prior. Claimant reported that she was fine after two or three weeks, and denied any residual effects from that injury. She did not inform Dr. London that she had been treated on and off for approximately a year following the injury. Dr. London opined that this would have been significant information, indicating that this injury was more severe than Claimant led him to believe. RX-22, p.9.

Dr. London reviewed Claimant's medical records including reports from Drs. Smith and DeFeo. Dr. London performed a physical examination on Claimant. He found that Claimant's gait was normal, she was able to walk heel-to-toe normally. Claimant had a full range of motion in her spine, except for forward flexion which measured seventy degrees.[43] Claimant complained

[43]Dr. London explained that most people can bend to about 90 degrees, but it varies. "Seventy may be all that she can do." RX-22, p.10.

of pain on maximum forward flexion and bending to her right side. She had tenderness at the lumbosacral junction and the right paraspinal muscles. Claimant's neurologic examinations of the lower extremities were normal, except for decreased sensation on the medial aspect of her right ankle and the plantar aspect of the right foot to fine touch. RX-22, p.10.

Dr. London reviewed an MRI scan taken on December 14, 1998. He found a narrowing and degeneration of the L5/S1 disc, with disc desiccation and a one to two millimeter disc bulge at that level. There was no abnormality in the facet joints at any level in the lumbar spine. Dr. London opined that these changes would have taken years to develop, and the MRI was taken two months after the injury. Thus, none of these findings were of an acute nature. "There is not enough time for those to have developed in a few months." RX-22, p.11. Dr. London opined that a one millimeter disc bulge is classified as normal or minimal. The disc bulge was not caused by the October 5, 1998 injury. RX-22, p.12.

Dr. London took x-rays of Claimant's low back. He noted no evidence of instability. RX-22, p.12. Dr. London was asked about Dr. Capen's opinion that the x-rays showed "hypermobility." Dr. London stated that he does not recognize "hypermobility" as a medical term in relationship to the spine. He stated that what he thinks Dr. Capen was implying was that Claimant has an abnormal amount of motion between the vertebrae. Dr. London disagreed with this finding.[44] RX-22, p.13. Dr. London agreed with the interpretation of the radiologist, Dr. Fisher, who noted the facet joints at that level were normal on the MRI scan. Dr. London noted normal facet joints on the x-rays. He stated that if there was hypermobility there would be secondary changes in the facet joints. "You should see accelerated wear if there is abnormal movement between one vertebra and another." Dr. London continued that there was no movement whatsoever between the L5/S1 vertebrae on the flexion and extension views. He is not sure where Dr. Capen is indicating that there is any hypermobility. RX-22, p.13-14.

On the x-ray, Dr. London noted there was sacralization of the last lumbar vertebrae, and narrowing of the L5/S1 disc. The disc between the sacralized vertebrae and the rest of the sacrum "was sclerosis [sic] on both sides of the narrowed disc space." RX-22, p.12. In laymen's terms, the last lumbar vertebra sometimes takes a configuration that is partway between a lumbar vertebra and a sacral vertebra. This vertebra is much more a part of the sacrum than most lumbar vertebrae. "That would actually decrease the amount of motion between the lumbar spine and the sacrum, and in my opinion, would lead to the narrowing of that disc." There are no discs at all in the sacrum. Thus, "sometimes when you see a transitional vertebra, the disc between that transitional vertebra and the sacrum is congenitally narrowed." This is caused by the way Claimant's spine developed as a child, and not by an accident. RX-22, p.14-15.

Dr. London's diagnosis as of October 13, 1999, was a lumbosacral strain, or a stretching injury to supporting structures, the muscles and ligaments of the lower back. He opined that the strain had no effect upon Claimant's congenital and degenerative conditions. RX-22, p.17.

[44]Dr. London further opined that hypermobility cannot be caused by a lifting injury. It may be caused by a violent trauma, that over time, could create instability. RX-22, p.16.

Dr. London testified that he did not agree with Dr. DeFeo that Claimant required surgery. Based upon the physical examination findings, the x-ray and MRI scan findings, the activity level of Claimant, balanced against the risks of the procedures Dr. DeFeo recommended, Dr. London felt surgery was not warranted. He stated that the greatest risk would be that Claimant's pain would be worse if she had the surgery. RX-22, p.17.

Dr. London opined that Claimant could return to work. He would restrict Claimant from work that involved lifting over 40 to 50 pounds. This restriction was not, however, attributable to the October 5, 1998 injury, but to Claimant's pre-existing congenital and degenerative changes at L5/S1. Dr. London opined that Claimant was permanent and stationary at the time of his October 13, 1999 examination, and most likely, prior to that date. Dr. London opined that Claimant was most likely permanent and stationary within eight weeks of the injury. The basis for this opinion was that a typical recovery period for a lumbar strain is less that three months. See RX-7, p.32, RX-22, p.18-19.

Dr. London reviewed surveillance videotapes taken of Claimant playing golf. He wrote a summary of his review, dated March 5, 2001. What was significant to Dr. London was that Claimant did not exhibit what he would call "pain avoidance behavior." He explained:

> In other words, she didn't conduct herself like an individual who had had a back problem. She bent over at the waist. She never supported her back by pushing her hands down when she was sitting in the car. She had an excellent range of motion on her golf swing. She was able to squat fully to line up a putt. Her gait was normal. So it was a lack of any manifestations of pain, combined with the fact that she was doing things in a way that most people wouldn't recommend people do if they have a back problem, like bending at the waist. RX-22, p.20.

Dr. London testified that he is familiar with the mechanics of golfing. When one swings a golf club, "there is a tremendous amount of twisting of the spine, with a slight degree of forward bending." This puts a great deal of stress on the lower back. For this reason, many golfers have low back problems, and people with low back problems have difficulty playing golf. When a person has low back pain, they "will contract their swing, and have a shorter back swing and follow through, a stiffer looking kind of swing. And I didn't see evidence of that in [Claimant's] case." RX-22, p.21.

Dr. London stated that he would expect golfing to exacerbate pre-existing, congenital conditions such as Claimant has. He would further expect this to occur regardless of the October 5, 1998 injury. Over a long period of time, this activity would cause a worsening of Claimant's congenital condition. "The repetitive twisting stresses on the lower back would tend to aggravate the degenerative changes in the disc at L5/S1." RX-22, p.21-22. Dr. London would not expect Claimant to golf two or three times a week if she suffered from hypermobility sufficient enough to

require surgery. The fact that Claimant golfed two to three times a week, over the last three years, supported his opinion that Claimant sustained nothing more than a lumbosacral strain on October 5, 1998. The fact that Claimant returned to golf within one or two months of the injury further supports this diagnosis. RX-22, p.22.

Dr. London examined Claimant again on December 10, 2001. Dr. London believed that Claimant had told him that she sought no treatment for a year and a half, between January 2000 and June 2001. This was of some significance to Dr. London. It indicated that Claimant's injury was a lumbosacral strain that had resolved itself. RX-22, p.23.

At this second examination, Claimant complained of frequent low back pain, worse with activity, better with recumbency, or laying down. She had pain radiating into both lower extremities, more on the right than the left. This pain was present for most of the day. Claimant had pain radiating into the posterior right hip about twice a month when she was doing activities such as lifting, carrying, bending, or stooping, vacuuming, prolonged sitting, and occasionally when she got into bed at night. RX-22, p.24. Dr. London stated that Claimants testimony at trial that she experienced back pain three to four times a month was inconsistent with what she had reported to him, and to Dr. Capen. This was a significant difference. This suggested an effort on Claimant's part to embellish her symptoms to Dr. Capen and to himself. Rx-22, p.35-36.

Claimant did not report to him, as she testified at trial, that she suffered on a daily basis, from a stabbing pain in the right hip which radiated down to her right foot. Dr. London opined that this sort of symptom would be consistent with radicular pain, but all her tests were negative for radicular pain. RX-22, p.37. See RX-11, RX-12.

Again, Dr. London reviewed Claimant's medical records, including Dr. Capen's report and the results of the neurologic testing performed on October 1, 2001. Significantly, there was no evidence on any of the neurologic testing, the EMG, and nerve conduction study, of radiculopathy, or neurologic abnormality or pressure on nerves in the lower back. This was consistent with Claimant's MRI scan. The neurologic testing did reveal a left peroneal neuropathy at the ankle, which Dr. London opined had nothing to do with the October 5, 1998 injury. The cause of this condition would usually be a strain injury to the ankle. RX-22, p.25-26.

After performing a physical examination, Dr. London found that Claimant's gait was normal. She was again able to walk heel-to-toe. Claimant was capable of single-leg toe rise on each foot without any difficulty. Her active range of motion was normal, and she flexed forward to ninety-five degrees this time. Claimant complained of pain at ten degrees of extension or straightening of her back. There was tenderness at the lumbosacral junction and the lateral aspect of the right hip. Deep tendon reflexes were plus three at both knees, plus two at both ankles. Straight leg raising at seventy degrees caused low back pain, but no radicular pain, indicating the test was negative bilaterally. Sensation was normal and there was no muscle weakness. Dr.

London stated that Claimant had greater forward flexion on range of motion testing than on his first examination, and Claimant's neurologic examination remained normal. RX-22, p.26-27.

Dr. London reviewed x-rays taken by Dr. Capen on September 20, 2001. They were consistent with the x-rays taken by Dr. London on October 13, 1999, showing the same congenital and degenerative conditions. They did not reveal any instability or hypermobility. Dr. London reviewed the MRI scan done by Dr. Capen as well. There were no significant changes in Claimant's condition since the December 14, 1998 scan. Dr. London stated in his report that he did not agree with Dr. Capen that Claimant would benefit from surgery, as she did not have any problem with mobility. He further disagreed with the amount of physical therapy Claimant was receiving, as Claimant had reported to him that she only got temporary relief for a brief period of time after each session. He did not believe physical therapy would be beneficial more than three years after the initial injury. RX-22, p.29-30.

Dr. London concluded that he was unable to explain Claimant's ongoing subjective symptoms on any objective orthopedic basis. He explained that he thought her degree of symptomatology was not consistent with her activity level, her physical exam, her x-rays, her MRI scans or her electrodiagnostic testing. "In other words, I would not expect an individual with the physical exam findings, x-ray, MRI scan finding, and electrodiagnostic tests to be having any significant symptoms." RX-22, p.35.

Regarding the fact that Dr. Capen first treated Claimant three years after the injury, Dr. London opined that it is more difficult to address a causation issue if the physician did not examine the patient closer to the time of injury. "If you see someone in and around the time of the injury, I think that's more helpful." RX-22, p.38.

Dr. London disagreed with Dr. Capen's opinion that Claimant had torn the annulus of the disc at L5/S1. The MRI reports from the radiologist do not reflect an annular tear. This is something that would show up on the "T2 weighted images." There was no sign of a tear on either MRI scan. RX-22, p.38-39. On cross-examination, Dr. London testified that an acute annular tear could escape detection on an MRI, but "the reaction to the tear would show up on subsequent MRIs." Dr. London explained this concept on re-direct. One aspect of an MRI is a T2 image, "and they show anything with fluid in it as a white shadow. And so, if you tear, and there is edema, fluid, or blood, or any sort of a healing reaction around an annular tear, it will show up as a bright white signal." None appeared on either of Claimant's MRIs, indicating there was no tear. When asked if this was always true, Dr. London responded "I haven't seen someone with a tear where it wasn't demonstrated that way." RX-22, p.45-46.

Dr. Capen testified that the only way to tell if there is a tear is to perform a diskogram. Dr. London disagreed with this opinion. A tear of the annulus would also cause pain more than three or four times a month. It was Dr. London's opinion that Claimant's pain came from the degenerative changes at the L5/S1 disc, and not a tear. He further opined that Claimant would

have those symptoms regardless of whether or not she was injured on October 5, 1998. RX-39.

At the time of his second examination, Dr. London had the benefit of a job analysis. See RX-13. Claimant could perform her usual and customary work, as reflected on that job analysis. RX-22, p.30-31.

Dr. London opined that an individual with Claimant's low back condition, without the October 5, 1998 injury, would be expected to have occasional low back symptoms. It would not be unusual to have these symptoms three or four times a month. Dr. London would expect it even more, if the individual played golf two or three times a week. RX-22, p.37.

On cross-examination, Dr. London testified that it is possible for asymptomatic and degenerative changes to be rendered symptomatic by trauma. Dr. London had no record of Claimant experiencing back pain between the old injury and her injury in 1998. Dr. London did not know Claimant golfed seven days per week prior to the injury in October 1998. He agreed that the decrease in frequency to two to three times per week would reduce the stress put on Claimant's back. RX-22, p.45.

Surveillance Evidence:

Two surveillance videos and a report by Horsemen Inc. were admitted into evidence on behalf of Employer. RX-17, p.208-218. The videos were taken on September 25, 1999, November 19, 2000, November 25, 2000, January 11, 2001, February 2, 2001, and February 3, 2001. The videos capture Claimant playing golf on September 25, 1999 and February 2, 2001.

On September 25, 1999, Claimant was videotaped playing a round of golf. The surveillance lasted from 11:15 a.m., until Claimant left the golf club at 3:55 p.m. The tape shows Claimant golfing over the course of approximately four hours. Claimant can be seen driving her golf cart, getting out of the cart and walking to the tee. Claimant is seen taking warm up shots, bending over to place her ball on the tee, and swinging her club.

At times, Claimant squats down to line up her shot. At other times, Claimant is seen bending over, one leg in the air, picking up her ball with one hand. Claimant climbs in and out of her golf cart, pulling clubs from her golf bag.

After her round of golf, Claimant is seen walking to her car, carrying her golf bag on one shoulder. She lifts her clubs into the trunk of her car. Claimant is seen changing her shoes at her car. Claimant raises each foot behind her, and removes her shoes. She is then seen bending over, one foot at a time on the rear bumper, tying her laces. Claimant then walks into the golf club, and emerges sometime later with her husband. She gets into her car and drives off.

The second surveillance episode is of Claimant playing golf on February 2, 2001. Again, Claimant is seen swinging her club, bending over to pick up her ball or club, crouching to line up

her shots, and driving her cart. Claimant takes two practice swings before teeing off. Claimant is seen bending over, one leg in the air, to pick up the flag off the green. She bends over straight legged, bending at the waist to pick up her ball.

ANALYSIS

Claimant asserts that as a result of the October 5, 1998 injury, she sustained a low back injury which did not become permanent and stationary until January 18, 2000, and this injury has not fully resolved. Claimant further asserts that, as a result of taking medication for her low back injury, her pre-existing gastrointestinal condition was aggravated, thus entitling Claimant to ongoing medical treatment for this condition. Claimant further argues that there is a significant potential that her low back injury will cause diminished capacity in the future. Claimant asserts that she is therefore entitled to ongoing medical benefits, as well as a *de minimis* award for future benefits.

Employer asserts that Claimant's low back injury was a sprain/strain injury, and fully healed within two to three months of the date of injury. It claims that the date of maximum medical improvement was October 13, 1999. Employer further claims that the gastrointestinal condition of which Claimant complains is non-industrial in nature. It was not caused by, nor aggravated by any medication taken by Claimant for her low back injury. Thus, Claimant is not entitled to any benefits, medical or otherwise, after October 13, 1999.

I. Causation:

There is no argument as to the cause of Claimant's low back injury. The parties have stipulated that the October 5, 1998 injury was industrial in nature. Thus, the Court need not analyze this issue under Section 20(a). However, as a result of the low back injury of October 5, 1998, Claimant asserts that she later developed an aggravation of her pre-existing gastrointestinal condition due to the anti-inflammatory medication prescribed to Claimant for her low back pain. Employer asserts that Claimant's gastrointestinal condition was a pre-existing condition that could not have been, and was not aggravated by Claimant's medication. Therefore, this condition will be analyzed under Section 20(a).

An injury compensable under the Act must arise out of and in the course of employment. Section 20(a) of the Act provides that "in any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary (a) that the claim comes within the provisions of the Act." 33 U.S.C. §920(a). Thus, to invoke the 20(a) presumption, the claimant must establish a *prima facie* case of compensability by showing that she suffered some harm or pain, *Murphy v. SCA/Shayne Brothers*, 7 BRBS 309 (1977), *aff'd mem.*, 600 F.2d 280 (D.C. Cir. 1979), and that working conditions existed or an accident occurred that could have caused the harm or pain, *Kelaita v. Triple A Machine Shop*, 13

BRBS 326 (1981). The presumption cannot be invoked if a claimant shows only that she suffers from some type of impairment. *U.S. Industries/ Federal Sheet Metal, Inc. v. Director, OWCP*, 455 U.S. 608, 615, 102 S.Ct. 1312, 1317 (1982) ("The mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer.") However, a claimant is entitled to invoke the presumption if she presents at least "*some* evidence tending to establish" both prerequisites and is not required to prove such prerequisites by a preponderance of the evidence. *Brown v. I.T.T./Continental Baking Co.*, 921 F.2d 289, 296 n.6 (D.C. Cir. 1990).

Claimant has put forth sufficient evidence to establish a *prima facie* case of compensability. Claimant was examined by Dr. Dimmick, who testified that Claimant's gastrointestinal symptoms stemmed from the use of anti-inflammatory medication prescribed for relief of her low back pain. Dr. Dimmick opined that Claimant's condition would continue to give her pain as long as she kept taking the medication. This evidence is clearly "some evidence tending to establish" that Claimant suffered some harm or pain, and that an accident occurred that could have caused the harm or pain. I therefore find that Claimant has presented evidence sufficient to invoke the section 20(a) presumption.

Once the Section 20(a) presumption is invoked, the burden shifts to the employer. To rebut the presumption, the employer must present substantial evidence that the injury was not caused by the claimant's employment. *Dower v. General Dynamics Corp.*, 14 BRBS 324 (1981). If the presumption is rebutted, it falls out of the case, and the administrative law judge must weigh all of the evidence and resolve the issue based on the record as a whole. *Hislop v. Marine Terminals Corp.*, 14 BRBS 927 (1982). The ultimate burden of proof then rests on the claimant under the Supreme Court's decision in *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251 (1994). See also *Holmes v. Universal Maritime Services Corp.*, 29 BRBS 18, 21 (1995).

Employer is able to carry its burden to rebut Claimant's *prima facie* case. Employer's expert witness, Dr. Grodan, testified that Claimant's gastrointestinal condition was not brought on by the anti-inflammatory medication Claimant was taking for her low back pain. Dr. Grodan opined that Claimant's condition was pre-existing, and furthermore, such a condition could not be aggravated by medication. Based on the foregoing, the undersigned finds that Employer has rebutted Claimant's *prima facie* case by substantial evidence.

The next step in the analysis is to weigh the evidence as a whole. Claimant has the burden of proof to show by a preponderance of the evidence that her gastrointestinal condition was caused, or aggravated by, the industrial injury she suffered on October 5, 1998. The undersigned finds that she has not carried that burden.

In arriving at a decision in this matter, it is well-settled that the fact-finder is entitled to determine the credibility of the witnesses, to weigh the evidence, and draw her own inferences from it, and she is not bound to accept the opinion or theory of any particular medical examiner. *Todd Shipyards v. Donovan*, 300 F.2d 741 (5th Cir. 1962); *Bank v. Chicago Grain Trimmers*

Ass'n, Inc., 390 U.S. 459, 467, *reh'g denied*, 391 U.S. 929 (1968). I am unconvinced by Claimant's testimony as a whole, and thus cannot include her testimony as proof of her gastrointestinal condition. Although Claimant appeared to be a credible witness at the hearing, after reviewing the evidence in this case, I find many discrepancies in her testimony, as well as important omissions on her part, which lead the undersigned to conclude that Claimant is not a credible witness.

There are many discrepancies in Claimant's testimony. Claimant testified that she had first suffered from gastrointestinal pain twenty-two to twenty-three years ago. Claimant then testified continually that she had not suffered from similar gastrointestinal symptoms between that incident and her recent back injury. When examined on the type of symptoms she did suffer from in 1990, when she was admitted to the hospital for two weeks, Claimant stated that they were not like the symptoms she suffers from now. They felt like something was wrong with her heart. Tr.120-121. She had no recollection that there was anything wrong with her stomach. However, Claimant described the symptoms she experienced in 1999 or 2000, her most recent flare-up, as similar to a heart attack. Tests were performed on her heart, and she testified "they just eventually just told me to stop taking my stomach medicine, or that medicine, it was really irritating my stomach." Tr.51-52. Thus, these symptoms that Claimant suffered from most recently, sending her to the emergency room, were in fact similar to those she experienced in 1990. The symptoms felt like a heart attack on both occasions, but were related to her gastrointestinal condition.

Although Claimant denied complaining of gastrointestinal problems between the late 1970s and 1999 or 2000, the medical records show otherwise. On February 12, 1990, at Antelope Valley Hospital, Claimant reported that she had suffered "epigastric and lower substernal discomfort" on and off for four years. CX-8, p.11. In March 1990, the Mercy Hospital records show that Claimant reported a history of "substernal epigastric area pain." CX-6, p.1. Claimant reported to Dr. Grodan that she had first experienced these symptoms approximately twelve years ago, in 1989 or 1990. RX-8. p.37. Whether Claimant does not remember making these reports, or did not know at the time that what she was experiencing was gastrointestinal symptoms, Claimant's testimony is not an accurate source for proof of her condition.

There were further discrepancies in Claimant's testimony. Claimant first testified that her current gastrointestinal complaints began approximately four or five months prior to her visit to the emergency room in September 2000. Claimant later revised this testimony, placing her first complaints five or six months prior to her October 6, 1999 visit to Dr. Guevarra. According to Dr. Guevarra's report, the reason for her visit to Dr. Guevarra was for a chronic cough, and that Claimant had not complained of any gastrointestinal symptoms at that visit, although Claimant did report to Dr. Guevarra that she had been diagnosed with gastroesophegeal reflux disease, "several years earlier."[45] CX-9, p.4. Claimant testified on cross-examination that the visit to Dr. Guevarra

[45]Dr. Guevarra did prescribe medication for Claimant's gastroesophegeal reflux disease at that visit, but notably, did not instruct Claimant to discontinue the anti-inflammatory medication. Dr. Guevarra instead instructed Claimant to discontinue her intake of caffeine, spicy foods, mint

was for a routine mammogram, and that she had not complained of stomach pain at all. It is difficult to decipher when exactly the symptoms at issue began, based upon Claimant's confusing and evolving testimony.

Claimant's testimony as to the frequency of her symptoms changed. Regarding her gastrointestinal symptoms, Claimant testified at trial that she experienced these symptoms every two or three days. At her deposition, Claimant had stated that they occurred once every two months, for two or three days at a time. Her explanation for the discrepancy was that over the course of the last year, her symptoms had changed. She can be sick once a month, or once a week. Tr.121-122.

Claimant testified at trial that she experienced pain in her legs, without pain in her low back. She testified that the pain in her legs is there "most of the time," giving it a rating of 9 out of ten on a bad day. Tr.57, 61. Claimant never reported any leg pain without simultaneous back pain to Dr. Capen, according to his testimony. CX-12, p.48. Regarding Claimant's low back pain, Claimant first testified that it occurred three or four times a month, however she reported to both Drs. Capen and London that she suffered from "frequent" low back pain. Claimant first testified that sometimes golf hurts her back, sometimes it does not. Claimant then stated that she has back pain "usually every time" she plays golf. Tr.124. Thus the frequency of Claimant's complaints ranges from three or four times a month, to eight to twelve times a month,[46] to "most, if not all of the time." CX-12, p.55-56; RX-22, p.35-36.

Claimant omitted important information when reporting to the doctors examining her. Regarding her gastrointestinal condition, although Claimant testified that she first began experiencing these symptoms twenty-two to twenty-three years previously, she neglected to report this fact to either Dr. Dimmick, her treating physician, or Dr. Grodan. CX-13, p.20; RX-23, p.10. Claimant misrepresented the history of her low back condition to both Dr. London and Dr. Capen. Claimant testified that she had suffered a low back injury in the mid 1970s, for which she was in treatment for about three months, and which caused her to miss approximately a year of work. Tr.49-50. Claimant did not report this injury to Dr. Capen, who testified that this would be considered a significant injury. CX-12, p.33. Claimant reported an injury to Dr. London, but stated that it resolved after only two or three weeks. Dr. London testified that this would have been significant information, indicating a more severe injury than he was led to believe. RX-22, p.9.

Claimant further neglected to report to either Dr. Capen or Dr. London that she was playing golf two to three times per week, beginning one month after her October 5, 1998 injury. CX-12, p.20; RX-22, p.22. This information changed Dr. Capen's opinion as to what job duties Claimant was capable of performing, and what restrictions he would impose. Dr. London felt that this information bolstered his diagnosis of a sprain/strain injury that had fully healed within three months of the initial injury.

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candy, alcohol and nicotine, and advised her to elevate the head of her bed. CX-9, p.5.

[46]This is based upon her testimony that she plays golf two to three times a week.

Claimant testified that the injury has impaired her ability to play golf. She played seven days a week prior to the injury and can only play two to three times a week now. Her swing is not as strong. She cannot play as well as she used to. It takes great preparation to play a round of golf. Tr.64-66. Upon looking at the records from Claimant's golfing tournaments, the court notes that since the injury, Claimant has won four golf tournaments. In each of these tournaments, Claimant was competing against both women and men. See RX-19.

Finally, there is the surveillance evidence of Claimant playing golf. The surveillance tapes show Claimant playing golf for three to four hours at a time, bending at the waist, twisting, crouching, and swinging a golf club, all without any indication of pain. They show Claimant riding around in a golf cart, getting in and out without any difficulty. Claimant exhibits no pain behavior during any of the footage. She does not reach for her back. Claimant swings her club without any noticeable restriction of movement. She does not grimace after a full swing. Claimant bends at the waist, reaching down for the flag, one leg in the air, with apparent ease. She bends down straight-legged to pick up her ball, without supporting her back. In direct conflict with this activity is Claimant's testimony that she experiences back pain after standing for fifteen minutes, as well as her testimony that standing, lifting, bending, walking and riding in a car all cause her pain. Tr.58-59.

Claimant is seen walking with a companion, carrying her golf bag without apparent difficulty. This is contradictory to her testimony that she does not carry her clubs to her car, and always drives her golf cart to the car in order to avoid carrying them if no one is available to help her. Tr.88-89. This surveillance evidence is in direct conflict with Claimant's testimony that she has back pain "usually every time I play golf." Tr.124.

Based on the foregoing, I do not find Claimant to be a reliable or credible witness. I have thus disregarded Claimant's testimony as proof of her condition. What is left then, is the testimony of the parties' medical experts. Because I give more credence to Employer's expert on the issue of Claimant's gastrointestinal condition than I do her treating physician, I find that the evidence shows that Claimant's gastrointestinal condition was a pre-existing condition and was not caused by, nor was it aggravated by the October 5, 1998 injury. Claimant is therefore not entitled to medical expenses for the treatment of her gastrointestinal condition, nor is she entitled to compensation for the specific injury she alleges to her gastrointestinal tract.

When considering medical evidence concerning a worker's injury, a treating physician's opinion is entitled to "special weight." *Amos v. Director, OWCP,* 153 F.3d 1051 (9th Cir. 1998). However, a treating doctor's opinion is not necessarily conclusive regarding a claimant's physical condition or the extent of her disability. See *Magallanes v. Bowen*, 881 F.2d 747, 751 (9th Cir. 1989); *Amos,* 153 F.3d at 1054, ("special weight" standard limited to treating doctor's opinion regarding treatment). Moreover, the court may reject the opinion of a treating physician which conflicts with the opinion of an examining physician, if the decision sets forth "specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Magallanes,* 881 F.2d at 751.

The Court finds Dr. Dimmick's opinion of Claimant's injuries unreliable, as he relies heavily on Claimant's inaccurate representations of her condition. Furthermore, Dr. Dimmick's findings are unsupported by the weight of objective evidence to the contrary. Dr. Dimmick made his diagnosis without the benefit of the results of Claimant's endoscopy. Once he reviewed the endoscopy, Dr. Dimmick felt no need to update his diagnosis in writing. Upon being provided with full information, Dr. Dimmick's diagnosis was no longer logical. In contrast, Dr. Grodan had the benefit of a more thorough history, as well as the benefit of the results of Claimant's endoscopy. Dr. Grodan's diagnosis was based upon objective evidence of Claimant's condition. Therefore, the undersigned finds Dr. Grodan's opinion well-reasoned and more persuasive than Dr. Dimmick's.

Dr. Dimmick had incomplete information when making his diagnosis. Claimant failed to report to Dr. Dimmick that she had first experienced gastrointestinal symptoms twenty-two to twenty-three years previously. Claimant gave Dr. Dimmick a history of her condition that glossed over her hospitalization in 1990, stating that she had been hospitalized for chest pain which had been thoroughly evaluated. Dr. Dimmick testified that the history he gets from his patient is "99% of what you're dealing with" in internal medicine. CX-13, p.21-22. Claimant was an inaccurate and unreliable source, upon which Dr. Dimmick placed great weight.

Dr. Dimmick further made his diagnosis without reviewing the endoscopy report of Dr. Poola. This report stated that Claimant's endoscopy was normal through the duodenum, with no mucosal changes, and no scarring. Dr. Dimmick did not think, as Dr. London did, that this report led to a conclusion that Claimant did not suffer from gastritis or irritation from anti-inflammatories. He opined that Claimant's symptoms could have dissipated in the 48 hours prior to the test, causing a normal result. What is bothersome about this opinion is that Dr. Dimmick stated that when gastric acid comes up repeatedly into the esophagus, it causes damage. The records indicate that Claimant had been suffering from these symptoms for approximately twelve to twenty-three years, symptoms that Dr. Dimmick correlated with acid percolating into Claimant's esophagus. CX-13, p.10-11. If acid had been percolating into Claimant's esophagus for such an extended period of time, by Dr. Dimmick's own testimony, there should have been scarring.

Dr. Dimmick stated that his diagnosis was partially based upon his belief that Claimant was suffering from stress, which would cause more acid to be produced, thus aggravating her condition further. This stress, Dr. Dimmick believed, was caused by Claimant's financial troubles, and the "stresses of pain." CX-13, p.36-37. It was this stress that accounted for Claimant's continuing pain even after discontinuing the use of anti-inflammatory medication. Dr. Dimmick came to this conclusion of his own accord. Claimant never reported that she was suffering from stress, financial or otherwise. This was an admitted assumption on Dr. Dimmick's part, and cannot be reconciled as a contributing factor to Claimant's condition.

Upon receiving complete information, Dr. Dimmick still felt it unnecessary to alter his diagnosis until he testified at his deposition. Dr. Dimmick wrote a supplemental report after reviewing Dr. Poola's report. Dr. Dimmick stated that his opinion had not changed in any respect.[47] At his deposition, however, Dr. Dimmick's diagnosis had changed. He now opined that Claimant suffered from a pre-existing motility disorder that was aggravated by the taking of anti-inflammatory medication, as well as by stress, causing more acid production in the stomach which was percolating into Claimant's esophagus and causing inflammation and pain. Dr. Dimmick merely felt that he had put the cart before the horse in his prior report, and that his diagnosis had not really changed. "Pain is pain." CX-13, p.30-33. Dr. Dimmick did not think the change was important enough to note in his supplemental report, yet Dr. Dimmick based his entire testimony on this changed opinion.

In contrast, the testimony of Dr. Grodan is logical, is based upon a more accurate medical history and complete medical records, and is supported by the objective evidence. Dr. Grodan reviewed records dating back as far as the mid-1980s, when Claimant's symptoms began. He reviewed the report from Dr. Poola. Dr. Grodan was aware that Claimant had been complaining of similar symptoms for approximately twelve years. Although Claimant did not report to him that she had experienced these symptoms twenty-three years ago, he did not feel that this information would have changed his diagnosis at all. RX-23, p.8-10.

Based upon the objective medical evidence, Dr. Grodan opined that Claimant suffered from a motility disorder that gave her the *feeling* of regurgitation, due to food hanging in the esophagus. This would explain why Claimant suffers from a feeling of acid in her throat, but the endoscopy revealed no scarring, or damage of any kind to the mucosa.

Dr. Grodan noted that in 1990, at Antelope Valley Hospital, the doctors did explore the possibility that Claimant's complaints stemmed from a gastric condition. An endoscopy was performed at that time. Reports throughout Claimant's medical history point to similar complaints. Dr. Grodan stated that the symptoms Claimant had been experiencing over the years could have been either cardiovascular or gastric, which explains why Claimant may not have realized that she had been suffering from this condition for many years. Cardiovascular problems create similar symptoms to gastrointestinal problems. Claimant's medical reports document a long history of gastrointestinal problems that were present while Claimant was not taking anti-inflammatory medication. These reports can be fully reconciled with Dr. Grodan's diagnosis of an esophageal motility disorder.

Dr. Grodan explained why he disagreed with Dr. Dimmick's diagnosis. He opined that Dr. Dimmick's diagnosis is illogical, and medically impossible. The endoscopy did not show any evidence of inflammation. One can argue that the inflammation went away prior to the test, but if a patient had a chronic reflux condition on and off for a dozen years, such as Dr. Dimmick felt that Claimant has, some type of scarring would show up on the endoscopy. Dr. Grodan testified

[47]Dr. Dimmick's original diagnosis was that Claimant's consumption of anti-inflammatory medication caused the motility disorder, leading to inflammation and pain.

that it is medically impossible for a motility disorder to be affected by anti-inflammatory medication. A motility disorder involves muscles within the wall of the esophagus. Anti-inflammatory medication can have no effect on the muscle structure of the esophagus, only the outside surface. Furthermore, Dr. Dimmick's diagnosis is inconsistent with Claimant's complaints of the onset of symptoms one or two years after she started taking the anti-inflammatory medication. These symptoms would have begun much sooner, if caused by the medication. Dr. Dimmick did not have any explanation for this timing problem.

In sum, there is little objective evidence to support Dr. Dimmick's diagnosis of motility disorder aggravated by anti-inflammatory medication and "this nebulous thing called stress." The more credible diagnosis is that of Dr. Grodan. Thus the undersigned finds that Claimant's gastrointestinal condition is a pre-existing motility disorder, and was not aggravated by the medication prescribed for Claimant's low back injury. Thus, this condition is not industrially related and Claimant is not entitled to medical benefits relating to its treatment.

II. Nature and Extent of Claimant's Injuries:

The burden of proving the nature and extent of disability rests with the claimant. *Trask v. Lockheed Shipbuilding Constr. Co.*, 17 BRBS 56, 58 (1980). Disability is generally addressed in terms of its nature (permanent or temporary) and its extent (partial or total). The Act defines disability as an "incapacity to earn the wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10). Therefore, the claimant must demonstrate an economic loss in conjunction with a physical or psychological impairment in order to receive a disability award. *Sproull v. Stevedoring Service of America*, 25 BRBS 100, 110 (1991). Thus, a disability requires a causal connection between a worker's physical injury and her inability to obtain work. If the claimant shows she cannot return to her prior job, it is the employer's burden to show that suitable alternate employment exists which she can perform. Under this standard, a claimant may be found to have sustained no loss, a total loss or a partial loss of her wage-earning capacity.

The parties have stipulated that Claimant is capable of performing suitable alternative employment at or above her pre-injury average weekly wage. Claimant in thus no longer disabled under the terms of the Act at this time. Claimant asserts, however, that there is significant potential that her low back injury is a continuing disability that may cause diminished capacity in the future. She therefore seeks a *de minimis* award for benefits. Employer asserts that Claimant incurred only a temporary total disability which had ceased upon her return to pre-injury employment, and that Claimant's recent pain complaints are attributable to her pre-existing back condition aggravated by her golfing, and not the industrial injury of October 5, 1998.

De minimis awards are appropriate where a claimant has not established a present loss in wage-earning capacity, but has shown by a preponderance of the evidence that there is a significant possibility of diminished capacity under future conditions. See *Metropolitan Stevedore*

Co., v. Rambo (Rambo II), 521 U.S. 121, 31 BRBS 54 (CRT) 1997. There are three conditions that must be satisfied before nominal compensation may be awarded: (1) a continuing disability, (2) no current loss of wage-earning capacity attributable to the subject injury, and (3) a reasonable expectation that the work-related injury will cause a loss in wage-earning capacity at some future point. *Id.* at 62.

The first step in the analysis is to determine whether Claimant suffers from a continuing disability, one that is industrial in nature. As discussed previously, I cannot credit Claimant's testimony as proof of her injury as she is not a credible witness. Thus I shall turn to the testimony of Drs. Capen and London. When considering medical evidence concerning a worker's injury, a treating physician's opinion is entitled to "special weight." *Amos v. Director, OWCP,* 153 F.3d 1051 (9th Cir. 1998). However, a treating doctor's opinion is not necessarily conclusive regarding a claimant's physical condition or the extent of her disability. See *Magallanes v. Bowen*, 881 F.2d 747, 751 (9th Cir. 1989); *Amos,* 153 F.3d at 1054, ("special weight" standard limited to treating doctor's opinion regarding treatment). Moreover, the court may reject the opinion of a treating physician which conflicts with the opinion of an examining physician, if the decision sets forth "specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Magallanes*, 881 F.2d at 751.

The undersigned credits the opinion of Dr. London over that of Dr. Capen, Claimant's treating physician. Dr. Capen did not begin treating Claimant until three years after the injury occurred. Dr. Capen examined Claimant on three occasions only, once more than Dr. London. Furthermore, Dr. Capen's diagnosis and opinions are based heavily on Claimant's unreliable and misleading reporting, and are contrary to the objective evidence. Upon learning the reality of Claimant's golf playing, Dr. Capen changed his medical opinion. Dr. London, on the other hand, first examined Claimant one year after the initial injury. He based his opinion and diagnosis on his objective findings, rather than Claimant's subjective complaints and misleading reporting of her medical history. Thus the undersigned finds Dr. London's opinion well-reasoned and more persuasive than that of Dr. Capen's.

Dr. Capen examined Claimant on three occasions in 2001, three years following Claimant's injury. Dr. Capen testified that it is unnecessary for a physician to examine a patient near the time of the injury. If there are medical records available, "and if the historian is reliable," it makes little difference if three years have passed. The flaw in this reasoning lies in the historian Dr. Capen relied upon. Dr. Capen testified that the history he took from Claimant, he relied upon to formulate "a great deal of [his] diagnosis." This history excluded the fact that Claimant had suffered from a low back injury in the mid-1970's, which caused her to seek treatment and stay off of work for approximately a year, an injury Dr. Capen agreed would be significant. Claimant further neglected to report that she had not received any treatment between January 2000 and June 2001. Dr. Capen suggested that Claimant was able to live without treatment through this period because she was still taking medication, although he was aware of no record that any doctor was prescribing medication to Claimant during this period. Dr. Capen came to this conclusion based upon Claimant's testimony that she was taking her husband and her sister's

medication during this period. CX-12, p.31-32, 81-82, 90. Most importantly, this history excluded the fact that Claimant had been playing golf two to three times a week since November 1998, one month after her initial injury, a fact that Dr. Capen admitted would change his medical opinion. CX-12, p.62-64.

Dr. Capen's diagnosis of an annular tear was not based upon any objective evidence. It was this tear that Dr. Capen opined was causing Claimant so much pain, along with scarring from her original sprain/strain injury. This tear did not appear in any of Claimant's x-rays, nor in her MRI studies. This diagnosis would explain why Claimant's x-rays showed no spinal cord or nerve root impingement. It would explain why all of Claimant's EMG and nerve conduction studies showed nothing that would cause radicular pain into her legs without correlating back pain, as Claimant testified to. It would explain Dr. Capen's diagnosis of hypermobility, which he testified was caused by the annular tear. In fact, all of Dr. Capen's findings could be explained by this annular tear.

This diagnosis does not, however, have any objective evidence to substantiate it. According to Dr. London an annular tear would be visible on an MRI scan, as there would be a leak of fluid, and fluid appears as a white signal on the film. Dr. Capen's testimony was that he would be "astounded" if Claimant did not have "a leak and an easily demonstrable annular tear." However, he asserted that it is rare that an annular tear would appear on an MRI. Dr. Capen stated that the only way to diagnose such a tear would be to conduct a discogram, an invasive procedure such as those Claimant had already refused to undergo. Dr. Capen did not mention his theory of an annular tear in any of his reports. See CX-3. The first mention of this diagnosis was during Dr. Capen's deposition, on cross-examination. See CX-12, p.40.

Dr. Capen was under the false impression that Claimant played golf only occasionally. He testified that he did not think it wise for Claimant to play more than once in a while due to the stress it would put on her upper and lower spine. Golfing may "not be in her best interest." Knowing her condition, he opined that "any rotational activities, on a repetitive basis, should be done with caution." Dr. Capen noted upon reviewing the surveillance film that Claimant exhibited no pain avoidance behavior. He stated "those films are take four months apart, and in and of themselves, absent your hypothetical, do not change my opinion expressed in my report." CX-12, p.60-62.

When informed of Claimant's golfing schedule, Dr. Capen changed his recommendations, stating that under these circumstances, "it would make it less necessary to preclude her from as many things as I stated in her job description." However, Dr. Capen continued to maintain the opinion that Claimant's low back injury of October 5, 1998 never fully healed and that it was still the source of Claimant's current pain. He admitted that Claimant's golf playing "would produce wear and tear, especially on a damaged disc such as the L5/S1 disc," and it would account for the increased narrowing, hypermobility, radiation of pain up the spine, "all of the above." Regardless, Dr. Capen maintained his opinion that the October 5, 1998 injury caused an annular tear, leading to Claimant's continued pain.

Dr. Capen first opined that all of the changes in Claimant's lumbar spine can be attributed to this tear and to the 1998 injury. "Some of the changes that we see now, and all of the symptomatology and the disc dysfunction itself, are due to the trauma that occurred when she got hurt." After learning of Claimant's golf habit, Dr. Capen further quantified his opinion, assigning two-thirds of Claimant's degenerative condition to the injury, and one-third to her golf playing. Dr. Capen's opinion is in direct conflict with the reports written shortly after her injury in 1998 and early 1999. On December 14, 1998, Dr. Fischer, a radiologist reading Claimant's MRI found "interspace narrowing with disc bulging, at most, 1-2 mm at L5-S1. There is associated disc degeneration at this level. Otherwise, the examination is normal." The lumbar myelogram similarly showed "degenerative disc disease at L5-S1." See RX-10, p.55-56. On March 4, 1999, Dr. Smith notes a "degenerated dehydrated flattened L5/S1 with reactive formation of the bone." See CX-2, p.1. On April 23, 1999, Dr. DeFeo notes that Claimant's myelogram shows degenerative changes at L5/S1. He states "she probably has an unstable degenerative joint at 5-1 [sic]." See CX-2, p.5. Dr. Capen's diagnosis is not supported by the objective evidence.

In contrast, although Dr. London was similarly misinformed by Claimant, his diagnosis was based upon the objective evidence, and was only bolstered by the true circumstances of Claimant's golfing habit. Dr. London first examined Claimant one year after the injury. At this initial examination, Dr. London found Claimant's gait was normal, she had full range of motion except for forward flexion, normal heel-to toe walk, and neurologic examinations were normal except for some decreased sensation in her right ankle, attributable to an ankle injury. Claimant's MRI showed degenerative changes that Dr. London opined would have taken years to develop. She had a minimal 1-2 mm disc bulge that was not caused by the injury. Claimant's x-rays showed sacralization of her last lumbar vertebrae, a condition caused by the development of Claimant's spine as a child. RX-22, p.10-14. Dr. London did not think that her October 5, 1998 injury had any effect on these degenerative conditions. He felt surgery was not called for. Claimant had suffered a sprain/strain which had fully healed by the time he examined her on October 13, 1999. The x-rays, MRIs, EMG and nerve conduction studies all corroborate this diagnosis, as does the continued activity level of Claimant.

Dr. London disagreed with Dr. Capen's diagnosis of an annular tear. This type of trauma would cause pain more often than three or four times a month. A torn annulus would have appeared on the MRI scan, or at least "the reaction to the tear" would appear on subsequent MRIs. His explanation for this opinion is well-reasoned. An MRI would show any fluid, blood or "any sort of healing reaction" as a white shadow. If Claimant had torn her annulus, it may not have appeared on the first MRI, but after three years, it would seem logical that any healing or worsening, such as the twisting and stress of golf exacerbating the tear, would be apparent on a later study. This was not the case. Claimant's most recent MRI studies show no trauma.

Dr. London did not know Claimant golfed two to three times a week, but instead of altering Dr. London's diagnosis, this information corroborated it. Dr. London had seen the surveillance video, and had reported that he saw no pain avoidance behavior. He did not feel Claimant conducted herself as someone with low back pain. "She had an excellent range of

motion on her golf swing." He asserted that the fact that Claimant golfed as much as she did supported his medical opinion, as did the fact that Claimant returned to playing golf one month after the injury. Dr. London noted that such activity would exacerbate Claimant's pre-existing condition, regardless of the October 5, 1998 injury. Over a long period of time, golf alone would cause a worsening of Claimant's congenital condition. This is a logical source for Claimant's current complaints.

Based on the foregoing, the Court finds that Claimant has not sustained a permanent impairment as a result of her 1998 industrial accident as the weight of objective evidence demonstrates that this injury caused only a temporary sprain/strain injury to her low back, which had fully healed by October 13, 1999. Any disability Claimant may suffer from is due to a degenerative condition, exacerbated by her golf playing. As Claimant is unable to satisfy the requirement that she sustained a continuing disability as a result of the subject industrial injury, there is no need to reach the other two prongs of the *de minimis* standard, that of current loss of wage-earning capacity attributable to the subject injury, and a reasonable expectation that the work-related injury will cause a loss in wage-earning capacity at some future point. [48] Claimant therefore, is not entitled to a *de minimis* award.

III. Maximum Medical Improvement:

An injured worker's impairment is deemed permanent if the condition has reached maximum medical improvement or if the impairment has continued for a lengthy period of time and appears to be of a lasting duration. *Watson v. Gulf Stevedoring Corp.,* 400 F.2d 649, 654 (5th Cir. 1968), *cert. denied*, 394 U.S. 976 (1969); *James v. Pate Stevedoring Co.*, 22 BRBS 271 (1989). "Maximum medical improvement" and "permanent and stationary" are legal concepts developed in case law to ascertain when a claimant's condition has moved from a temporary to a permanent status.

Permanency does not, however, mean unchanging. Permanency can be found even if there is a remote or hypothetical possibility that the employee's condition may improve at some future date. *Watson*, 400 F.2d at 654; *Mills v. Marine Repair Serv.*, 21 BRBS 115, 117 (1988). Likewise, a prognosis stating that the chances of improvement are remote is sufficient to support a finding that a claimant's disability is permanent. *Walsh v. Vappi Constr. Co.*, 13 BRBS 442, 445 (1981); *Johnson v. Treyja, Inc.*, 5 BRBS 464, 468 (1977).

The date a claimant's condition becomes permanent is a question of fact to be determined by the medical evidence and not by economic or vocational factors. Thus, the medical evidence must establish the date on which the claimant has received the maximum benefit of medical

[48]The parties have stipulated to the second factor, that Claimant suffers no current loss of wage-earning capacity attributable to the subject injury. See Stipulation #10, p.3. The third factor cannot be established, as I have already found that Claimant's work-related injury has fully resolved.

treatment such that his condition is not expected to improve. See *Trask*, 17 BRBS at 60; *Mason v. Bender Welding & Mach. Co.*, 16 BRBS 307, 309 (1984).

Claimant contends that she reached maximum medical improvement on January 18, 2000, based on the permanent and stationary report of her treating physician at the time, Dr. DeFeo, issued the same day. While Dr. DeFeo's opinion as Claimant's treating doctor is entitled to great weight *(Amos v. Director, OWCP*, 153 F.3d 1051 (9th Cir. 1998)), it is not necessarily conclusive and may be disregarded, even if uncontradicted. *Magallanes v. Bowen*, 881 F.2d 747, 751 (9th Cir. 1989). Based on substantial evidence in the record it appears that Claimant's condition became permanent and stationary much earlier than the January 18, 2000 date proposed by Dr. DeFeo.

The undersigned credits the opinion of Dr. London over that of Dr. DeFeo. Dr. DeFeo did not testify, thus the undersigned does not have the advantage of Dr. DeFeo's explanation for his opinion. Dr. DeFeo did not review any past medical reports in making his diagnosis. He was not fully informed by Claimant as to her medical history or her present situation. His opinion is based upon Claimant's unreliable and incomplete reporting of her condition. Dr. DeFeo took very little medical history from Claimant. He did not know Claimant suffered from an injury to her low back in the late 1970s. He reviewed no past medical records, according to his reports. Furthermore, Dr. DeFeo did not know the extent to which Claimant was playing golf throughout the period she was under his care. He noted that she had told him that she enjoyed golf in her free time. As was Dr. Capen, Dr. DeFeo was misinformed as to Claimant's golfing habits and her physical capabilities.

Dr. DeFeo concluded that Claimant's condition was the result of a work-related injury, which did not reach maximum medical improvement until January 18, 2000. This conclusion is not supported by his findings. From his first report on March 4, 1999, only five months following the injury, Dr. DeFeo noted the MRI revealed "degenerative, dehydrated flattened L5-S1, with reactive formation of the bone." The disc herniation was minimal. He reported "no major defects." Yet he felt that discograms were in order.[49] Claimant's EMG was normal, showing no sign of radiculopathy, yet Dr. DeFeo diagnosed right L-5 radiculopathy secondary to an unstable joint at L-5. Dr. DeFeo reported in June 1999 that once Claimant was fitted for her TLSO brace, she could return to her usual and customary work. He could address her permanent and stationary status three to four weeks after she began using the brace. Claimant's fitting was scheduled for July 26 and 27, 1999. Thus, Claimant should have been released to work sometime in late August or early September. However, Dr. DeFeo did not release Claimant until January 18, 2000. There is no explanation as to why Dr. DeFeo waited so long to release Claimant, other than Claimant's subjective complaints that her pain was worsening. As I find Claimant's subjective reports unreliable, I also find that Dr. DeFeo could not draw reasonable medical conclusions based on them, and Dr. DeFeo's conclusion that Claimant did not reach maximum

[49]Dr DeFeo found sensory loss on the dorsum of Claimant's foot and weakness in the extensors, but based upon the opinion of both Dr. London and Dr. Capen, these findings were not related to the October 5, 1998 injury. See CX-12, p.49, RX-22, p.26.

medical improvement until January 18, 2000 is not supported by the objective evidence.

As discussed previously, the undersigned finds the opinion of Dr. London to be well-reasoned and based upon objective findings, rather than Claimant's subjective and inaccurate reporting. Dr. London released Claimant to work without restriction on October 13, 1999. He pronounced Claimant permanent and stationary at that time. Claimant suffered from a sprain/strain injury as a result of the October 5, 1998 accident, which should have healed within two to three months. Claimant returned to playing golf two to three times a week within two months of her injury. Thus, the evidence supports a finding that the date of maximum medical improvement was October 13, 1999.

IV. Section 7 Benefits:

Section 7(a) of the Act, 33 U.S.C. § 907(a), states that "[t]he employer shall furnish such medical, surgical, and other attendance or treatment . . . for such period as the nature of the injury or the process of recovery may require."

Section 7 requires the employer to furnish the injured employee with medical care that is reasonable and necessary. *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). The claimant has the burden of proof to show that the medical services are related to the compensable injury, *Pardee v. Army & Air Force Exchange Service*, 13 BRBS 1130 (1981), and are reasonable and necessary. The claimant is not aided by the section 20(a) presumption, which applies solely to the issue of compensability. *Schoen v. United States Chamber of Commerce*, 30 BRBS 112, 114 (1996); *see also Buchanan v. International Transportation Services*, 31 BRBS 81, 84 (1997). The claimant establishes a *prima facie* case when a licensed physician states that the treatment is necessary for a work-related condition. *Turner v. Chesapeake & Potomac Telephone Co.*, 16 BRBS 255 (1984).

Claimant argues that Employer is liable for all outstanding medical bills of Dr. Capen. As Claimant reached maximum medical improvement as of October 13, 1999, Claimant is not entitled to Section 7 benefits for any treatment received after that date. Employer is not liable for the medical bills of Dr. Capen, who first examined Claimant September 20, 2001, well after Claimant's industrial injury to her low back had completely resolved.

V. Section 8(f) Relief:

The Court need not reach the issue of Section 8(f) relief, as Employer is not liable for any permanent disability compensation.

VI. Attorney's Fees and Costs:

Under Section 28 of the Act, a claimant may recover reasonable and necessary attorney's fees and costs associated with the "successful prosecution" of her claim. 33 U.S.C. § 928. Here, Claimant has failed to successfully prosecute any of her claims. Employer has voluntarily paid Claimant any benefits she was entitled to, and is not liable for future benefits. Thus, Claimant is not entitled to attorney's fees and costs.

Conclusion

Claimant has not sustained her burden in proving that her gastrointestinal condition is industrial in nature.

Employer is thus not responsible for any future medical benefits arising from Claimant's gastrointestinal condition.

Claimant has failed to establish that she is entitled to a *de minimis* award for benefits for her low back injury. Claimant's industrial injury was a sprain/strain injury and was fully healed by October 13, 1999, the date of maximum medical improvement.

Accordingly, Employer is not responsible for the medical bills of Dr. Capen, nor any other medical bills which accrued after October 13, 1999.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, and based upon the entire record, the Court issues the following order:

Claimant shall take nothing.

IT IS SO ORDERED

A

ANNE BEYTIN TORKINGTON
Administrative Law Judge

ABT:lc